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**The role and purpose of generalist day centres for older people
Case studies of four day centres from multiple perspectives**

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The role and purpose of generalist day centres
for older people: case studies of four day centres
from multiple perspectives

Katharine Elizabeth Orellana

Thesis submitted in fulfilment of the requirements for the
degree of Doctor of Philosophy

2018

Institute of Gerontology
King's College London

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Abstract

This thesis investigated the role and purpose of generalist English day centres for older people, a largely ignored and under-researched part of social care that has been affected by changing policy, practice and funding contexts.

Using mixed methods within an embedded multiple-case study design, this thesis paints an in-depth picture of four day centres. It reports perspectives of four participant groups (n=69), gathered in 2015-16 by interview and standardised measurement tools: centre attenders, their family carers, day centre personnel and local authority adult services staff.

Findings illustrate the diversity of day centres and challenge assumptions concerning their continued relevance by evidencing that outcomes for their mainly housebound and socially isolated attenders, family carers and centre volunteers are precisely those targeted by social care and health policy. Centres were communities that 'enabled' and offset loss or isolation, thus supporting ageing in place through wellbeing. They promoted wellbeing in (younger) older volunteers, provided job satisfaction, supported carers and contributed something unique to their attenders', volunteers' and staff's lives. Findings from the completion of the Adult Social Care Outcomes Toolkit indicated attenders' and carers' quality of life improvements were directly attributable to day centres. By monitoring attenders' health and wellbeing and providing practical support, information and facilitating access to other services, centres offered added value. Fundamental to outcomes were the group environment and continuity that centres provided. Attenders' experiences were mainly positive, but were sometimes negatively affected by increasing proportions of cognitively impaired attenders.

Mainly, day centres were not stigmatised, but awareness of them before attending one was low. The study identified the potential for development and optimisation of day centres to maximise the impact of health and care services; partnership working with these, and with community organisations, were variable. Implications for policymakers and practice are made and recommendations for further research provided.

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Chapter 1 Introduction

In this introductory chapter, I recount how this study originated and give an overview of the changing context and the research gap which prompted it. Next, I set out its aims, objectives and research questions, what is outside its scope, some definitions and summarise its intended contribution to the evidence. Finally, I summarise the thesis structure.

Chapter 2 outlines the policy and research background in more detail and the theoretical perspectives underpinning the study.

1.1 Background to this study

The study reported in this thesis investigated the role and purpose of day centres excluding those specialising in the care of people with dementia, how they were viewed and the context in which they were used. These day centres are a largely ignored, yet important, part of social care for many older people in England. The research was triggered by two articles written by colleagues at King's College London's Social Care Workforce Research Unit, published while I was interning there, a previously-developed interest in day centres and a fortuitous funding opportunity.

In the aforementioned articles, Manthorpe and Moriarty (2013,2014) highlighted the difficulties of researching a service described by its location rather than its aims or what it offers, the gaps in and overall lack of evidence about English day centres and the importance of the availability of data for those funding such services or purchasing them on behalf of individuals.

Why did I find this fascinating? I had developed an interest in day centres over the 14 years I worked at a voluntary sector organisation concerned with improving life for older people. While there, I noticed changing nomenclature of services despite provision, essentially, apparently remaining similar. During a development project, I discovered that providers were often unaware of the differences between their own and other day centres, although there were shared concerns and challenges.

This interest and the articles led me to wonder what day centres really did offer, why and to whom? Was the essence of what a day centre provided very similar to what it had always been or had there been a shift from passive receiving of care to active participation in activities by attenders? Was there a need for a modernised definition of a day centre? How would a definition incorporate the full spectrum of day centres' apparent preventive nature? These questions could not be answered without further research to investigate their role, how they were perceived and to update the 'who' and 'what' of day centres.

Shortly after the articles were published, the Dunhill Medical Trust published a call for applications for its Research Training Fellowships which I pursued successfully. The proposal for this doctoral study was grounded in the dearth of research evidence on day centres as whole entities, the wider organisational changes occurring in care commissioning and the ongoing efforts to integrate health and social care, outlined next, which presented an opportunity to start to fill a perceived evidence gap.

1.2 The changing context

Day centres have been an integral part of social care since the National Assistance Act 1948 (HM Government 1948). This Act permitted local authorities to contribute to voluntary organisations that provided recreational facilities, such as day centres, for adults with disabilities. This was extended to include older people by an amendment to the Act in 1962 (HM Government 1962).

The relevance of day centres for older people has been challenged (Leadbeater 2004, Tyson *et al.* 2010, Needham 2014) within the current English policy context of personalisation of social care (Department of Health 1998, 2010), a marketised social care environment (HM Government 1990) and reduced public funding for social care (Dunning 2010, Fernandez *et al.* 2013, Ismail *et al.* 2014). Day centres, particularly those offering low-level support, are commonly being closed or decommissioned (ADASS 2011) despite evidence that some older people would like to attend them (Bartlett 2009, Wood 2010, Needham 2014, Miller *et al.* 2014). Commissioning decisions are not always informed by service users (Miller *et al.* 2014) and consultations informing decisions are reportedly variable (Orellana 2010, Needham and Unison 2012). Within this context of change, it is important to better understand the purpose, benefits and perceptions of day centres and identify gaps in the evidence. Yet national data is difficult to obtain in England as day centres are not required to register centrally. The scant English data cover people aged over 65 in receipt of Local Authority provided or commissioned services.

1.3 The research gap

The gaps in evidence about English day centres highlighted by Manthorpe and Moriarty (2013, 2014), and others, were confirmed by a review of the literature published from 2005-2017, the findings of which appear in Chapter 4. From this review, I concluded that, although there is some evidence about their impact and the outcomes of some interventions taking place within them, day centres for older people without dementia are under-researched generally, particularly in England. Research in or about day centres, published during the period 2005-2017, tended to focus on specific groups of people, activities or relationships rather than the day centre as an entity, considering the wider stakeholders. There was a lack of evidence about the context in

which day centre attendance took place, for example whether people using them received support from social networks and/or other parts of the social care system. Data on their levels of frailty and well-being were scant and few studies documented what was offered by the day centres.

It is, therefore, important to broaden the evidence about day centres, particularly since much of the English research in this area is outdated as the policy and funding context in which day centres exist has changed. This study addresses the 'how', 'what', 'why' and 'who' questions concerning day centres that have been neglected in research.

1.4 This study: aims, objective and research questions

This research aims to improve the understanding of day centres' purpose and role, how they are viewed and their use within a changing policy and practice context, thereby contributing to the evidence base in social care for older people and those supporting them. It employed a rigorous approach to bring together various perspectives to gain a better understanding of day centres' role in social care. A secondary aim is to discover whether collecting data about day centre users using standardised measures might form a robust evidence base for day centres which they might find useful in their own business planning.

Its objective was to paint an in-depth, rich and contemporary picture of day centres for older people, what they offer, who uses them, why, how and what they contribute to the lives of those involved in them, how they are perceived and how they relate to health and care services and, finally, to discover the usefulness of collecting data about day centre users using standardised measures.

These aims and objectives were translated into the following research questions which are addressed in this thesis:

1. What is already known about the purpose of day centres, how they are perceived, who benefits from them and how?
2. Which older people attend day centres and why, what are their experiences of doing so and what are their connections with other parts of their lives?
3. What are the outcomes of day centre attendance for older people, their carers, and volunteers and staff working at day centres?
4. How do potential commissioners and referrers/signposters (e.g. social workers) perceive day centres and why?
5. What service do managers and owners believe their day centre offers, how do they view its place within the market of social care provision and its relationships with local community and health services, and what are their plans for the future?

The first research question was answered by a review of the literature from 2005-2017 which confirmed the need to address questions 2-5 (see Chapter 4). Case studies of four day centres provide in-depth pictures of these and what they offer (see Chapter 5). Four participant groups were interviewed to gather data that would address the variety of perspectives required to address questions 2-5 (see Chapters 6-9). These embedded case study groups were:

- older attenders of these centres
- family carers of attenders
- day centre managers, frontline staff and volunteers
- local authority commissioners and frontline staff who may refer or signpost to day centres.

Before defining these groups, I note that centres that specialise in the care of older people with dementia are outside the scope of this study. This is because of the sizeable international evidence base, including literature reviews, about day centres, or interventions in them, for people with dementia or their carers (Quayhagen *et al.* 2000, Zank and Frank 2002, Gaugler *et al.* 2003a, Gaugler *et al.* 2003b, Woods *et al.* 2006, Gustafsdottir 2011, Zarit *et al.* 2014, Tretteteig *et al.* 2015) and because a study of the value, meaning and purpose of a day centre for people with dementia in England was being undertaken from 2014-16 at the University of Manchester (Health Research Authority 2015).

1.5 Definitions

To contextualise the subject, it is first necessary to define day centres and the four participant groups in this study.

1.5.1 Day centres

Day centres are building-based services. They may differ in what they offer, their target clientele, admission criteria, ownership, size, building used and the way they are funded. In addition to the well-used service names of 'day centre' and 'day care', the terms 'day service' and 'day opportunities' have come into use over recent years, both very broad in what they could, potentially, encompass (Moriarty and Manthorpe 2012). The latter may also refer to daytime activities that are not building-based. Even where services share names, they are seldom identical. Changing terminology adds a layer of complexity to the discourse around day centres and to the generation of evidence about what are, essentially, undefined interventions or series of interventions.

Definitions of day centres have developed around their target users, their setting, when they operate and 'what' they provide. A well-used 1981 'day unit' definition, which described the

setting, provider and operating schedule (Carter 1981) was criticised (Tester 1989) for making no reference to the people using such services or what the service offered. Based on her seminal study of day care services for older people in England and Wales, which identified five key objectives of day care and nine reasons for attendance, Tester proposed that a definition should take also account of the reasons for attendance, who and what it is for and the setting it takes place in. A later discussion of definitions (McVicker 2004) suggested that the U.S. National Adult Day Services Association's (NADSA) definition was the most comprehensive. This encompassed target users, the setting, times of operation, what is offered to attenders and potential outcomes for carers. It has since been updated and continues to include these elements (NADSA 2015).

Retaining the 'who', 'what', 'where' and 'when' definitional elements, in this research day centres are defined as community building-based services that provide care and/or health-related services and/or activities specifically for older people who are disabled and/or in need, which people can attend for a whole day or part of a day.

1.5.2 Older people

The term 'older people' is defined differently according to context and is commonly the state pension qualification age, although the World Health Organization, within a global context, has also defined an older person as '*a person whose age has passed the median life expectancy at birth*' (World Health Organization 2015:230). In the gerontological field, older people are sometimes divided into three sub-groups in recognition of the diversity that exists within such a wide age group: young old, middle old, oldest-old (von Humboldt and Leal 2014).

In this study, the term 'older people' is being used flexibly but is largely defined according to the participating day centres. Thus, 'older people' may be any age from 50 upwards, which coincides with the UK Department of Work and Pensions' definition of 'older' (HM Government 2005) but, in the main, older age is used to refer to the general pension qualification age of 60 or 65 years.

Older people who attend day centres are referred to in this thesis as 'attender(s)' as this is felt to lack the passivity that may be associated with the terms 'attendee'. The term 'user' was considered unsuitable as day centres are also used by carers of attenders, for respite, and by professionals who commission or refer to them as tools to support their own work.

1.5.3 Carers

The Care Act 2014 defines a carer as '*an adult who provides or intends to provide care for another adult*' (HM Government 2014: Chapter 23, Part 1, 10.3, p10). In this study, 'carer' refers to a person providing unpaid care, or support, for a family member or friend who cannot cope without this support due to their illness, disability or a mental health problem.

1.5.4 Day centre managers, frontline staff and volunteers

A day centre manager is someone employed by a centre's providing organisation to manage its day-to-day or its overarching operation. Frontline staff and volunteers are people – paid or unpaid - working directly with centres' older attenders during a day centre day.

1.5.5 Local authority commissioners and frontline staff who may refer or signpost to day centres

Local authorities are responsible for shaping the market and, to an extent, commissioning what services are available for people to use (HM Government 2014). Commissioning has been defined as *'the cycle of assessing the needs of people in an area, designing and then achieving appropriate outcomes'* (Cabinet Office 2010:7). Local practices vary (Bovaird *et al.* 2014).

A variety of people working in health or social care may refer or 'signpost' to, that is give information about, day centres. Professionals typically in contact with older people in need of care and support and carers include general practitioners (GPs), nurses, social workers and occupational therapists. Local authority employees without professional qualifications also carry this out as part of assessment or case work, for example, after a person has approached social services. These people are termed 'signposters/referrers' throughout this thesis.

Both commissioners and signposters/referrers might be considered to be beneficiaries of day centres as the ability to refer to them or fund them may contribute towards meeting their own targets, for example within outcomes frameworks and concerning the health and wellbeing of older people, meeting the needs of carers or the management of long-term conditions (Department of Health 2013).

1.6 Intended contribution of this study

This research contributes to the evidence base in social care for older people and those supporting them. It is policy, practice and intellectually relevant.

In the current UK environment of reductions of public funding to social care, and with increasing numbers of older people, many of whom live alone, it is important to understand who day centres benefit, how and why, how they are perceived and their place within the mosaic of health and social care. Only once these are known will it be possible to refute or uphold the notion that day centres no longer have a purpose or that they need to find a new place in social care.

These findings may help to inform service providers and policy makers regarding the relationship between day centres and older people's wellbeing. A better understanding of day centres and their users may contribute towards informing professionals' decisions about funding, referring

and signposting. This is important because non-evidence-based assumptions may leave day centres at risk of cuts or closure, potentially reducing people's care and support options. The findings may also assist day centres in planning or re-designing day centres as well as acting as a foundation for further research.

This study's originality lies in the multiplicity of perspectives gathered, the in-depth nature of its case studies and its consideration of a day centre as a whole service. Although there was some evidence about their impact, day centres have been under-researched as whole services and contextual evidence was lacking.

1.7 Outline of this thesis

This introductory chapter has provided a brief background to this study. The remainder of this thesis is structured as follows.

Chapter 2 provides more detail about the changing policy context and its impact on day centres and the research background. It also sets out the theoretical perspectives underpinning the study.

The methodological approach and methods are set out in Chapter 3, namely mixed methods within a multiple-embedded case study design. Details of sampling, selection, recruitment, tools used and fieldwork methods are presented and data analysis strategies discussed. Next, ethical and Research Governance considerations and challenges are summarised. Finally, the methods for undertaking the systematic scoping review of the literature published in English between 2005 and 2017 are detailed. Chapter 4 presents the findings of this review, thus, addressing research question one concerning what was already known about the purpose of day centres for older people without dementia, how they are perceived, who benefits from them and how.

The following five chapters present the findings of the fieldwork stage of the research.

In-depth case studies of the four day centres appear in Chapter 5. Each starts with a brief area overview. After describing the provider and premises, detail is given about centres' aims, target users, attenders, operational days and hours, its funding and charges made, a timetable of the research day, details of meals provision, transport, organised activities, any opportunities for involvement, staffing and links with community and voluntary organisations, health and social care. This is followed by a narrative account of the day the fieldwork took place.

The views of day centre managers and local authority employees are the focus of Chapter 6 which addresses research questions four and five. Their perspectives on the current and potential role and purpose of day centres set the scene for the findings presented in the following three chapters which concern the characteristics of and outcomes for attenders, family carers and day

centre volunteers and staff. For these three groups, within-group analysis was undertaken due to the small samples.

Chapter 7 addresses part of research question two by outlining the characteristics of the participating attenders and their motivations for using their day centres. It then recounts and reviews the experience of collecting data from attenders and carers using standardised measures from the perspective of the potential use of these within day centres, such as for monitoring purposes or business planning.

The outcomes and experiences of older attenders appear in Chapter 8 which encompasses their outcomes, measured quantitatively and reported qualitatively, the unique contribution that day centre attendance has made to their lives and their favourite aspect of attending. This is followed by their experiences and feelings about their centres, their least favourite things about centres and suggestions for change. The chapter concludes with family carers' and centre volunteers' and staff's perceptions of outcomes attenders gain. This chapter addresses the second part of research question two and part of question three.

The final findings chapter, Chapter 9, addresses the remainder of research question three by reporting the characteristics of and outcomes for family carers, day centre staff and volunteers as well as their feelings about their centres. Part 1, covering carers, ends by reporting attenders' perceptions of family carers' outcomes. Part 2, covering volunteers and staff does not cover others' perceptions of their outcomes.

In the final two chapters, findings are discussed, strengths and limitations of the study and implications stated, recommendations for further research made and personal reflections shared.

Chapter 10, the penultimate chapter, opens with a brief recap of the context of the study, its objectives and methodology and summarises its main findings. It then discusses these in the context of their contribution to other evidence, current debates and the theoretical framework for this thesis.

Finally, Chapter 11 highlights the original contribution of this study to the body of evidence about social care for older people and those supporting them, and explains the significance of its findings. After summarising the strengths and limitations of this study, this chapter offers some personal reflections on the methodology, fieldwork, ethical concerns and the topic itself. Implications for policymakers and practice, and recommendations for research, about which the Study Advisory Group and case study site representatives attending a workshop were consulted, are then stated. Finally, conclusions are drawn.

The references are followed by the appendices which include evidence of ethical approval, a scanned Disclosure and Barring Service check certificate, the research tools, summary tables of literature reviewed for Chapter 4, and illustrative examples of the coding manual and attenders' 'maps of the week'.

1.8 Summary

This chapter has provided brief background to the context for the study and highlighted the gaps in evidence which this study aims to fill. After setting out this study's aims, objective and research questions, definitions of day centres and the four individual participant groups were given and its intended contribution stated. Finally, the structure of this thesis was outlined.

Further details of the policy and research background are provided in the next chapter which also sets out the theoretical perspectives which underpin this study.

Chapter 2 Background context and theoretical perspectives

This chapter describes and explains the context in which this study has taken place. It does not summarise existing historical accounts of the development of English social care policy or day centres (e.g. Thane 2009, Tester 1989, Tucker *et al.* 2005). Instead, it outlines the policy environment and the impact of policy-related changes on day centres and on older people. The research context in which the study was conceived is then described. Finally, the theoretical perspectives used to interpret this study's findings are set out.

2.1 Policy context

The Care Act 2014 (HM Government 2014) requires local authorities in England to arrange services that promote wellbeing and help prevent or delay deterioration, and to support a market that delivers a wide range of care and support services. It continues the themes that have featured strongly across policy for several decades: promotion of good health and well-being, prevention of decline, and voluntary or community support to both older people and carers, and enabling people to choose to remain at home while growing older, to 'age in place' (HM Government 2012, 2010, Department of Health 1998, 2006).

Further to the increased emphasis on a market of social care, by the NHS and Community Care Act 1990 (HM Government 1990) which rendered local authorities enablers rather than providers, people eligible for publicly funded social care have been transformed into consumers of services by the adult social care policy of 'personalisation'. Personalisation, a central part of the 'transformation' (modernisation) of adult social care (Department of Health 1998), was conceptualised as a route to improving outcomes through empowerment, by giving people choice and control over their care and support in order to better meet individual needs and preferences and sustain continued independence and societal participation (HM Government 2007, Department of Health 2010). Self-management would replace the paternalistic Professional Gift Model, under which professionals define support services to meet presenting needs and 'gift' these to needy people - thereby undermining individual autonomy and presuming inability to make choices about support - using tax-payer provided resources transferred by the government (Duffy 2014).

Assessing and planning care and support in a person-centred way and individualising finances were key, and would enable '*individually tailored support packages*' (HM Government 2007:3), as would transparency of the resource allocation process. To enable flexible services, personalisation was expected to involve '*reduction of inflexible block contracts*' and budget-pooling (Department

of Health 1998:15). People eligible for public funding may currently (2018) opt to receive cash (direct payments) with which to purchase care or it may be organised on their behalf (managed personal budgets).

These policies are set against a backdrop of reduced funding and declining numbers of older people with higher needs receiving publicly funded care (Dunning 2010, Age UK 2015, Ismail *et al.* 2014, Fernandez *et al.* 2013), a move from low-level support to more intensive support and a reduction in voluntary sector services funded by block grants (Fernandez *et al.* 2013).

Outcomes Frameworks for social care, health and public health were introduced in 2014-15 (Department of Health 2013). The social care framework focuses on enhancing the quality of life of people with care and support needs, delaying and reducing the need for care and support, ensuring that people have a positive experience of care and support and safeguarding vulnerable adults. The health framework has similar themes. Annual reports against frameworks are informed by national surveys undertaken by local authorities.

2.2 Impact of policy changes

The policy of personalisation, marketisation of social care, a shift to competitive tendering and budget cuts are impacting on day centres for older people. Tensions arise when implementing policy in a context of funding changes with differing interpretations of what constitutes a key driver, and when assumptions predominate over evidence.

Both from an older people's perspective and more broadly, the fundamental principles and the implementation of personalisation have been subject to considerable analysis, debate and criticism (e.g. Barnes 2011, Moran 2006, Needham 2012, 2013, Scourfield 2007, Spicker 2013, Needham and Glasby 2014, 2015, Powell 2012, Roulstone and Morgan 2009, Lymbery and Postle 2015). Topics covered include interpretations of the concept; overshadowing of its outcomes-improving 'spirit' by take-up of individualised funding mechanisms; inadequately transparent resource allocation systems; lack of financial resources required for successful implementation; its potential contribution to efficiencies, its (un)suitability and (in)effectiveness for different groups of people; failure to acknowledge the varying circumstances of different groups of people; assumptions concerning a universal desire for individual services, and the ethics of a statutory shirking of responsibilities. Furthermore, while the notion of choice underpins policy, the potential for financial savings is argued to be of similar importance (Lymbery and Postle 2015) despite the limited potential for reducing public funding being acknowledged (e.g. National Audit Office 2011).

Regarding service options, the framing of choice in social care as an individual matter is argued, by some, to ignore the fundamentally public nature of social care (Stevens *et al.* 2011) in which individual choice may impact on others. There are several aspects to its public nature, including funding and access to services. Lymbery and Postle asserted that *'there is little understanding that the choice that one person makes might tend to affect the range of options open for another. For example, if 30 users of a local authority day centre decide not to use that service it may well become unprofitable and have to close, denying the choice of another 30 users that the service should remain unchanged.'* (Lymbery and Postle 2015:83). This point relates to the quasi-market in which social care services operate. Although intended to offer greater choice, control and satisfaction to 'consumers' (Audit Commission 2006), market oversight is variable (National Audit Office 2011). Despite user and carer need and market analyses being central to strategic commissioning principles (Audit Commission 1997), consultations about day service provision that inform 'strategic' commissioning by local authorities vary in scope, length and responsiveness (Needham and Unison 2012, Orellana 2010). Commissioning decisions are not always based on evidence or service user feedback (Miller *et al.* 2014). Needham concluded, based on her analysis of the narratives of personalisation advocates and a survey, that a combination of personalised funding with funding cuts *'has led to inadequate attention to the potential for an undersupply of collective and public goods (...) without sufficient responsiveness to how and what individuals want them to commission'* (2013:1). Thus, local authorities may be contravening market principles of supply and demand. Additionally, dubitable intimations that core funding or subsidising services alongside providing personalised funding means double-funding services seemingly also influence commissioning practice (Orellana 2010).

Local authorities no longer view day centres as a core service (Needham 2014) and their decommissioning or closure is increasingly common (ADASS 2011, 2014), particularly those providing low-level support (ADASS 2011). Closures are justified by changing policy and funding structures which, some believe, render day centres an outdated service model (Tyson *et al.* 2010, Needham 2014, Leadbetter 2004). This is despite some older people expressing a wish to access them (Needham 2014, Bartlett 2009, Wood 2010, Miller *et al.* 2014), a preference reportedly different from that of younger people with physical or learning disabilities or mental health problems (Wood 2010).

Changes are impacting on older people in different ways, but evidence of the scale and impact of these is partial and the bigger picture unknown. One problem is that data about day centres operating in England are not collected nationally as they are not required to register as part of monitoring or regulation. Another is the lack of centralised records meaning that little is known of

the day centre, or other, services purchased by the 8-10% of publicly-funded care users receiving direct payments or funding their own services (Manthorpe and Moriarty 2014).

Nevertheless, some data are available. Approximately 10% of people aged over 65 using local authority provided or commissioned community services attended day centres from 2011-14, accounting for the largest proportion of out of home services among this group (NHS Digital 2014, 2013b, 2013a). In 2013-14, just over half of these 59,300 attenders were physically frail or disabled (54%, n=31,390) while 19% had dementia (n=11,330) and 3.8% hearing, vision or dual sensory loss (n=2,290) (NHS Digital 2014). Figures for 2014-15 are not available due to the introduction of a new reporting system using the overarching category 'community' services.

There is some evidence from the voluntary sector that some individuals have lost their day centre support almost overnight while others experienced greater choice as centres became free to innovate once released from restrictive block contracts (Orellana 2010) and people use their personal budgets to access mainstream community services. However, some centres have restricted eligibility to people with high support needs while others have increased charges substantially (Needham and Unison 2012, Orellana 2010).

2.3 Research context

The findings of the last detailed study of day care in England and Wales were published in 1989 (Tester 1989). Funded by the Department of Health and Social Care, it aimed to inform the debate about day centres. The study, which included day care for people with dementia and day hospitals, reviewed provision, coordination of services, the role of day care within social care, identified challenges for providers and attenders and how monitoring and evaluation may be undertaken. Tester identified five key objectives of day care: helping people remain independent in the community, social care and company, rehabilitation and treatment, assessment and treatment, providing support for carers. She also identified nine reasons for attendance: prevention; social care and stimulation; developing or maintaining physical and mental skills; relief, respite or support for carers; assessment, monitoring, providing individual packages of care; basic personal care services; rehabilitation and treatment; social and physical support and advice for individuals. Although Tester's study took place over 25 years before this study, in a different policy and service environment, the findings may act as a benchmark against which to compare the findings of this present study.

Following Tester's study, other research has found that use of day centres can help people to remain at home, delaying costly moves to care homes (Andrew *et al.* 2000, Davies *et al.* 2000 cited in Wanless Review Team 2005). Their potential to act as locations for rehabilitative therapy

by health staff was demonstrated by a UK randomised control trial in which outcomes were similar for people receiving treatment in day centres or a day hospital (Burch and Borland 2001). Carer strain also declined. Both health and social care staff felt the benefits of working together. Negative perceptions of day centres, however, led to high refusal rates among people randomised to day centres in this study. The opportunities for social contact that day centres provided were valued by attenders in the UK (Powell and Roberts 2002) and the US (Turner 2004). Attenders and their carers in Powell and Roberts' (2002) study also highly valued the friendly environment, being involved in decision-making, day centres' person-centred nature, the relief offered to carers and the way that centres helped attenders to frame their lives in a positive way and maintained their independence. Attenders in Turner's study (2004) said their day centre meal was their most important nutritious meal of the day and some participated in activities which many reported benefiting from. Through the centres, participants also obtained information about power of attorney, 'living wills' and various types of health and medical support. Detailed case studies of day centres are few. Smith and Cantley's study (1985) was of a psychogeriatric day hospital. Gubrium's study (1986) was set in a dementia centre. Tester (1989) dedicated part of one chapter to seven very brief case studies of different types of centre.

The literature published from 2005-2017 that is relevant to the topic of this study is set out and evaluated in Chapter 4. Building-based day centres are commonplace, yet I found these were under-researched as whole services, with overview pictures of day centres, what they offer, to whom and how people perceive them emerging as gaps in the literature. This literature review identified little about the individual or systemic role, purpose or place of day centres that is relevant to an English setting. Although there is some evidence concerning the psychosocial benefits of attending a day centre, little is known about other outcomes, what people particularly enjoy about their time at a day centre or why and how they access them. Outcomes for carers of attenders and for people volunteering or working in day centres have been neglected. It is not known whether day centres offer some sort of 'added value' to individuals involved in them and the system. Indeed, it remains unclear what place day centres do, or might, occupy in the market of care and support that operates within an English policy context which prioritises prevention, early intervention, carer support and assistance to remain independent. Neither is it known how they interact with social care, community and health care services.

Thus, we can conclude that much of the research about day centres in England was either undertaken in a different policy context than currently or concerned people with cognitive impairment. Furthermore, there are substantial gaps in the evidence about them.

2.4 Theoretical perspectives

As a study grounded in the substantial policy and practice change that has taken place over the past 25 years, a social policy perspective was taken. Theories of ageing in place and day centres as potentially stigmatised institutions were drawn upon to maximise this thesis' relevance and contribution within the current contexts.

Ageing in place has been a long-term policy of successive governments (Means 2007). It means growing older with changing needs while receiving support services that enable continued independence in one's own home (Phillips *et al.* 2010, World Health Organization 2015). There is an assumption that remaining in one's own, long-term environment is beneficial for quality of life, more cost-effective for public funds (Tinker 1997) and addresses the increased support needs associated with growing numbers of oldest-old people (Tinker *et al.* 1999).

Meaning is often attached to 'home' which may be conceived as a place of 'warmth, sentiment and attachment' (Higgins 1989:14), '*a personal power base and a source of self-identity*' (Willcocks *et al.* 1987:7). Private homes also offer more privacy, familiarity, informality and freedom than group living settings (Higgins 1989). Thus, there is a tendency to associate remaining at home with maintenance of quality of life, wellbeing, independence and autonomy (Phillips *et al.* 2010, Sixsmith and Sixsmith 2008). Although remaining at home potentially enables continuity of community, critics argue that, at its worst, it can mean living in isolation in an unsuitable environment (Phillips *et al.* 2010, Sixsmith and Sixsmith 2008, Higgins 1989, Plath 2008).

In their review of the conceptualisation of stigma, Link and Phelan observed that 'stigma is defined in different ways by different investigators' (Link and Phelan 2001:364). Stigma pertains to devaluation of a given target which may result in negative behaviours (Baumeister and Vohs 2007). As a socially constructed concept, targets of stigma may vary with time. Stigmatised locations include residential institutions and stigmatised concepts include welfare.

Residential institutions have been stigmatised as undermining people's self-identity (Goffman 1961) and operating structures that create and reinforce dependency (Townsend 1981). As day centres are sometimes characterised by similar organisational structures, it has been argued that they, too, are institutions albeit 'partial' institutions as they only operate during the day (Townsend 1981, Salari 2002). Discussing interpretations of 'community care', Higgins claimed that day centres provided '*"community care" in the institution*' since people travel from home to day centres for their care (Higgins 1989:7).

A second source of stigma relates to welfare (Stuber and Schlesinger 2006). According to Tester, who carried out a year-long study of day care for older people in England and Wales, *'day centres, largely used by working class people, are somewhat stigmatised partly because they stem from welfare legislation'* (Tester 1989:76). The mind-set of older generations, familiar with the workhouses operating under the Poor Law that were abolished in 1930 (HM Government 1929), may have remained less positive. However, people growing up after World War II are said to recognise welfare as a reassuring 'safety-net' (Lymbery and Postle 2015:59), and it has been argued that *'the sense of stigma that characterised the Poor Law no longer exists'* (Lymbery and Postle 2015:85).

Negative depictions of day centres, for example as 'desolate places' in which people are unlikely to make friends (Cottam 2009:4), may have contributed to the de-legitimisation of day centres as places (Needham 2014) despite the support they may purport to offer people to age in place.

Recognising that experiences of ageing in place may not always be positive (Hillcoat-Nallétamby 2014, Plath 2008), another perspective is that day centres may offset feelings of loss and isolation by offering an alternative community (Hillcoat-Nallétamby 2014) regardless of its construction. Thus, they may function as a location of enablement for those involved with them by virtue of their congregate nature. This view contests the notion that attenders are passive recipients of care (Townsend 1981), acknowledges that attenders value their day centres (Tester 1989) and that day centres may positively impact on experiences of ageing in place and uphold the importance of choice.

Sections 2.1 and 2.2 of this thesis detail how interpretations of policy, practice change and perceptions have contributed to reductions in day centre provision. Additionally, funding reductions have shifted enactments of prevention from the intended early intervention and maintenance to prevention at the higher end of need, namely of institutionalisation (Hudson & Henwood 2008), which refocuses the aim of social care to support ageing in place as a cost-saving measure instead of an active choice for wellbeing. Constructing this thesis around social care's overarching purpose and directly addressing supposed reasons for day centre irrelevance or non-use enabled exploration of centres' individual and systemic role and purpose from a meaningful angle in this context. This framework also covers identified gaps in the research and theoretical lenses applied. Although gerontological literature has increasingly focused on ageing in place (Vasunilashorn *et al.* 2012), this has tended to be a rationale rather than an outcome of interest (Lehning *et al.* 2017), and policy-related theory is lacking in the 2005-17 day centre literature (see 4.8.3). Further research was needed about specific services' influence on ageing in place experiences (Vasunilashorn *et al.* 2012) particularly since outcomes and experiences of people

receiving publicly-funded services and carers are monitored by the Annual Social Care Survey, but day centre data are no longer reported separately. As a service to which people may self-refer or access after determining eligibility by assessment, older people's and carers' perceptions of day centres were as pertinent as those of local authority agents involved in commissioning or referring who, purportedly, are playing a role in centres' disuse.

In discussing the findings in relation to these underpinning theoretical perspectives (see 10.8, 10.9 and 10.10), centres' valuable sustaining role for people with mobility restrictions and/or who are isolated is highlighted and negative assumptions about day centres emerge as unsubstantiated. Contrarily, centres enabled choice and control which are central to feelings of independence in the context of remaining at home. Considering perceptions from the standpoint of stigma revealed day centres as simply an unknown entity rather than stigmatised welfare services. Given the increase in eligibility criteria for social care services and the decrease in available funding, numbers of older people ageing at home in similar circumstances as study participants will rise, yet their (and commissioners') perceptions have implications for the likelihood of day centre places being individually commissioned.

2.5 Summary

This chapter has provided the background context in which this study was conceived. It has detailed the changing policy context and its impact on day centres, and outlined the research context, indicating the extent of the gap in evidence. Finally, it has outlined the theoretical perspectives underpinning the interpretation of this study's findings.

The next chapter covers the methodological approach used in this research.

Chapter 3 Methodology

This chapter presents the overall methodology and methods employed in this study. It starts with a discussion of the overall methodological approach taken. After outlining the sampling and recruitment strategies and actual recruitment, fieldwork conduct and data management and analysis techniques are described and discussed. Then, ethical and research governance approvals and considerations are set out. The chapter finishes by detailing the methods used for the literature review.

3.1 Overall methodological approach

In this section, I discuss the choice of using a case study design and mixed methods, and outline 'stakeholder' input to the study.

3.1.1 Case study design

Two seminal studies influenced the choice of research design: Tester's (1989) study of day care services and facilities in England and Wales and Smith and Cantley's (1985) pluralistic evaluation of a new psychogeriatric day hospital in England. These illustrate both the complexity of day centres and the importance of considering the views of multiple stakeholders.

Tester's study aimed to identify the main issues related to the debate about day care in the context of the changing policy and practice environment of the time. It involved a survey of social services departments, seminars and workshops and a small number of case studies (n=7) of different types of day care and day hospital. She asserted that *'the systematic evaluation of day care services is fairly complex. To evaluate a service using a 'rational' model entails specification of desired outcomes and of criteria for evaluation. This is not a simple matter when services and their objectives are not clearly defined and when the different groups involved have different and possibly conflicting priorities for the multiple aims of the service'* (Tester 1989:141).

Smith and Cantley (1985) highlighted the importance of context for findings, dedicating a full chapter to describing the setting of their case study. They also subscribed to the view that gathering multiple perspectives contributed to more balanced conclusions since it enabled data to be collected from people who supported and people who opposed the initiative being studied.

The variety of objectives of this research was addressed by using mixed methods within an embedded multiple-case study design.

A case study is an empirical inquiry, a strategy for studying a phenomenon in depth (Yin 2014, Cresswell 2013, Stake 1995) in its contemporary context (Yin 2014, Cresswell 2013) which uses

multiple sources of evidence (Yin 2014, Stake 1995, Cresswell 2013). It is well-suited to research involving 'how' and 'why' questions (Yin 2014), to capturing complexity (Stake 1995) and incorporates flexibility according to the particular case being studied (Stake 1995, Yin 2014, Hyett *et al.* 2014).

A 'case' has defined boundaries (Yin 2014, Miller and Salkind 2001). The 'phenomenon' may be an individual, situation, organisation, group, period, policy, system (Robson 2002, Thomas 2011, Yin 2014). In this study, it is the day centre for older people which is a complex, building-based service. Although a complex service, its location allows demarcation of its boundaries.

To address the gap that was noted in individual-level data (Dabelko and Zimmerman 2008, Manthorpe and Moriarty 2014), additional embedded units of analysis for this study were the participant sub-groups associated with day centres, or their 'users': older attenders, their family carers, centre staff, volunteers and managers and local authority commissioners and frontline staff who refer or signpost people to day centres. These groups were defined in Chapter 1.

Common criticisms of case study research design (see Flyvbjerg 2006, Hyett *et al.* 2014) concern the type of knowledge case studies produce, that they lack rigour, cannot explain causal mechanisms, cannot be generalised, and contain bias. Supporters of this design (Yin 2014, Flyvbjerg 2006) reject these criticisms, claiming that multiple sources of evidence improve construct validity, that strategic selection of cases enables generalisability, that the risk of bias is not greater than other forms of research and that case studies can contribute to the development of knowledge. Whether or not case studies should be generalisable is debatable since generalisability is less crucial than the use that is made of them (Ruddin 2006). It has been argued that inferences can be made, regardless of case representativeness, when analysis is valid and is set in a relevant theoretical framework (Clyde Mitchell 2000). It is, therefore, the researcher's responsibility to provide sufficient detail and context, or 'thick description', for the reader to take their own decision about whether that case may be generalised to a particular field or context, thus externally validating stated conclusions (Lincoln and Guba 1985). Furthermore, using multiple data sources potentially enables triangulation which also contributes to the validation of findings (Lewis *et al.* 2014). Davies and Dodd (2002) argued that there should be different understandings of the concept of 'rigour' in quantitative and qualitative research, and that rigour may be built into qualitative research through processes and the implementation of the research itself.

A case study may be descriptive, exploratory, explanatory, comparative or evaluative (Yin 2014). According to Yin (Yin 2014), those that are exploratory aim to identify patterns and construct interpretative models. Descriptive case studies aim to present characteristics. Explanatory case

studies are concerned with explanations or analysis. Following Yin (2014), this thesis describes the real-life context in which the day centre occurs and explores the day centre as an intervention that may have no clearly stated set of outcomes. Case studies are both descriptive and explanatory. This research did not test a hypothesis.

The use of multiple and embedded cases in this research aimed to enhance coverage of different types of day centre and a range of 'users'. This was designed to foster reliability, rendering the findings more generalisable within the field of social care for older people.

As a study investigating 'how', 'why' and 'what' questions, observational methodology was not used since these are questions to which one cannot observe the answers. Observation is, nonetheless, a helpful method to explore social care, particularly so when participants lack some ability to communicate.

3.1.2 Mixed methods

Despite its greater resource intensiveness than single method research (Teddlie and Tashakkori 2012), mixing methods, which this study does, has become common practice in research (Ritchie and Ormston 2014). Doing so is increasingly seen as '*a good thing*', especially by research funders (Mason 2006:3) as it can produce distinct types of evidence which can merge into '*a powerful resource to inform and illuminate policy or practice*' (Ritchie and Ormston 2014:40).

As a descriptive, explanatory study aiming to improve the understanding of day centres, taking a pragmatic approach towards gaining knowledge (Johnson *et al.* 2007, Morgan 2007) prompted mixed data collection methods. This drawing on the strengths of different approaches (Johnson *et al.* 2007) helped to gain in-depth insights into day centres' role and purpose for individuals and ascertain their measurable impact. This was intended to enhance the findings' usefulness (Johnson *et al.* 2007, Ritchie and Ormston 2014) by maximising the breadth and depth of evidence (Collins *et al.* 2006, Mason 2006), thus contributing new, integrated and comprehensive knowledge (Collins *et al.* 2006, Moran-Ellis *et al.* 2006).

Following mixed methods research's guiding principle, '*methodological eclecticism*', research design was led by the phenomena of interest and how best to investigate it (Teddlie and Tashakkori 2012:776). Participants' perceptions, reasons, outcomes and experiences were explored qualitatively since this approach takes the participant's, rather than the researcher's, perspective (Punch 1998). Two types of quantitative data were gathered for different purposes. First, participants' characteristics were measured quantitatively to support analysis of qualitative data and contextualise the findings. The intention was not to carry out statistical analysis which would necessitate larger samples of each participant group. Second, attender and carer outcomes

were quantified using a validated tool which indicates their relative value to the individual, with a secondary purpose of evaluating its potential use by day centre personnel. Unlike those who perceive qualitative and quantitative methods as incompatible (Teddlie and Tashakkori 2012), I conceive no incompatibility problems since outcomes data were gathered from the same samples and concern the same topic. Such concurrent designs are not uncommon in exploring experiences, outcomes and processes in US health research (Plano Clark 2010).

A potential limitation of mixed methods research concerns privileging one method over another since this influences data presentation (White *et al.* 2014). Combining methods is argued to be more effective when each is valued equally (Ritchie and Lewis 2014) because of how they triangulate with each other:

'each perspective testing and adding to or validating the other (...) can each make up for the 'methodological blind spots' of the other to provide a 'fuller' picture of the phenomenon being studied' (Ritchie and Ormston 2014:40).

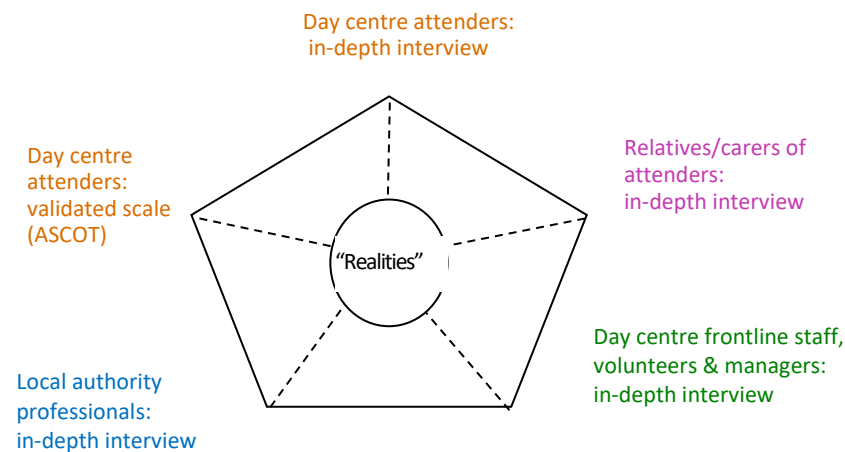
In this study, neither method subordinates the other; data are complementary, despite this researcher's qualitative preference. Not separating findings methodologically supports broader knowledge dissemination (Stange *et al.* 2006), although certain audiences (e.g. health professionals or commissioners) may prefer quantitative data (see also Section 11.5).

In addition to maximising the evidence about outcomes, triangulation of selected data was planned, between methods and between participant sub-groups' perspectives. For example, every participant group was asked about outcomes for day centre attenders which would enable triangulation of the following data (Figure 1):

- in-depth qualitative data gathered in interviews with attenders
- use of the Adult Social Care Outcomes Tool (Netten *et al.* 2011) that measures 'Social Care Related Quality of Life' (SCRQoL), that is quality of life with respect to day centre attendance
- gathering different perspectives of perceived outcomes attenders gain.

While it was envisaged that findings of the first two may corroborate each other to a certain extent (O'Cathain *et al.* 2010), multiple realities were also expected to emerge from other perspectives. Thus, qualitative and quantitative findings would complement each other even if there was contradiction between findings (O'Cathain *et al.* 2010).

Figure 1: Multiple sources of understandings of outcomes for day centre attenders



3.1.3 Patient and public involvement (PPI)

At the start of the study, a Study Advisory Group of seven people was recruited. The four participant sub-groups were represented among its members. The group met three times during the study. Members' views were sought as part of the planning process to develop recruitment methods and materials and interview materials that were clear and appropriate for each participant group (Ritchie and Lewis 2014). Questions to be asked of attenders and carers were also tested with a separate Advisory Group that acts as a critical friend to my host Unit at King's College London. The Study Advisory Group also provided feedback on my interpretation of the findings which were shared at the third meeting to which I presented draft implications and recommendations. Case study site representatives attending a workshop were also consulted about these.

3.2 Sampling approach

In this section, the day centre and individual samples are specified, sampling criteria detailed and sample numbers achieved outlined. After describing selection and recruitment methods, the recruitment of day centres and individual participant groups is reported. The next section covers the conduct of the fieldwork.

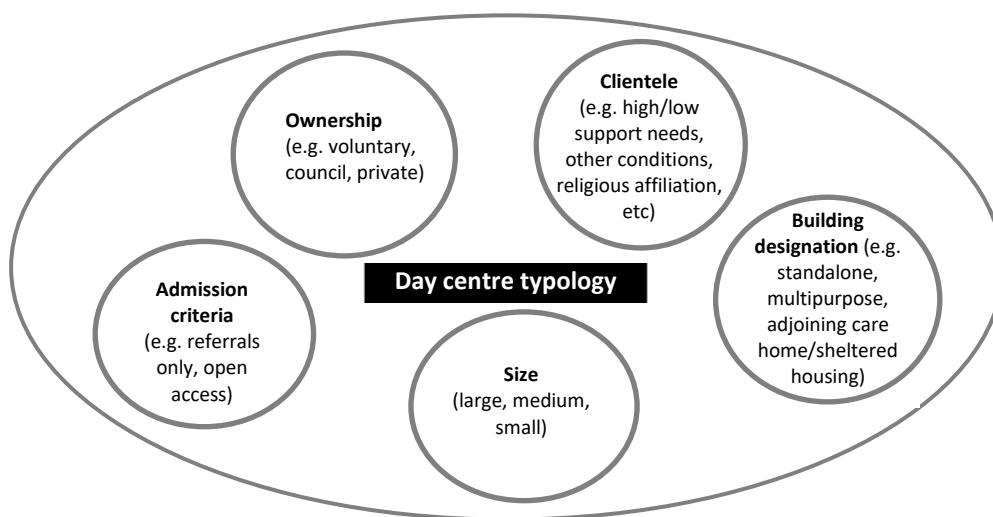
3.2.1 Sample

Day centres are the case studies in this research. Each has four participant groups of 'users', the embedded case studies: 1) older attenders of day centres, 2) their family carers, 3) day centre staff, volunteers and managers, and 4) local authority professionals who commission or signpost or refer to them.

3.2.2 Rationale for key sampling criteria and quotas

A typology of five factors that can vary between day centres (see Figure 2) was used to construct a matrix against which to devise a sample of up to four day centres covering a range of different typologies. Taking this purposive and maximum variation strategy to sampling (Cresswell 2013, Bryman 2012) aimed to ensure that the day centres recruited were heterogeneous and illustrative of their diversity and to maximise diversity between individual participants. To further maximise diversity within the study, day centres were located in areas with differing population characteristics under two different local political administrations. Due to time and expense constraints, centres were in the South East of England.

Figure 2: Typology of day centres



In this study, target recruitment numbers varied between individual participant groups. Those set were judged to be sufficient to gain insights into outcomes, to understand perceptions, to explore who attends day centres, and why, and their experiences.

Maximum quotas in each day centre were specified for attenders ($n=10$), their family carers ($n=5$) and day centre staff, volunteers and managers ($n=6$). This was to reduce the potential for feeling coerced to participate and because numbers of potential participants would be restricted by centres' daily capacity.

Minimum numbers of participants were set at two per day centre for local authority professionals. This was to cater for the participation of at least one commissioner and at least one frontline signposter/referrer for each day centre and aimed to allow flexibility in the event of local enthusiasm of participation.

3.3 Selection and recruitment methods

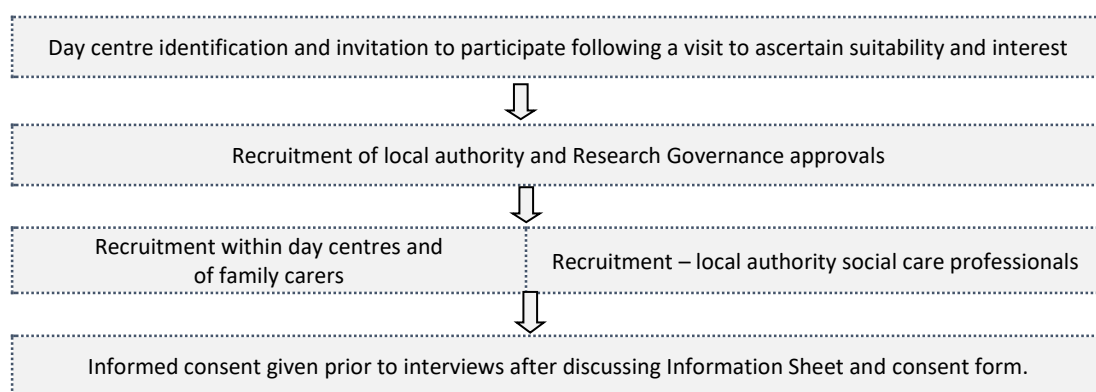
This section opens with an overview of sampling methods used and the recruitment process. It then presents the selection and recruitment methods used and actual recruitment of each participant group.

3.3.1 Overview of sampling methods and the recruitment process

Non-probability sampling was employed throughout. After purposively recruiting four day centres, convenience sampling of individual participants was undertaken. Local authority social care professionals were identified using snowball techniques (Bryman 2012).

Figure 3 summarises the recruitment process.

Figure 3: Flow chart of recruitment process



A crucial element of inclusion and exclusion criteria (see Box 1) was informed consent.

Box 1: Inclusion and exclusion criteria

Inclusion criteria
<ul style="list-style-type: none">○ Involved with day centre on a given day (decided with its manager), further defining the boundaries of each case: to maximise similarities in experiences, since activities and the profile of attenders/carers may differ greatly between days within a day centre.○ Has capacity to give informed consent (following the principles and provisions of the Mental Capacity Act 2005 that capacity must be assumed) (Department for Constitutional Affairs 2007)○ Able to engage with questions that require insight and understanding of 'higher order' concepts such as hypothetical situations○ In same area as day centre (local authority social care professionals)○ Gives informed consent.
Exclusion criteria
<ul style="list-style-type: none">○ Day centres specialising in dementia care or palliative care (e.g. in hospices)○ Attenders lacking capacity to consent or engage with questions relating to 'higher order' concepts. The nature of significant cognitive impairment requires a different research design and research exploring similar questions was underway elsewhere in England at the start of this study (Health Research Authority 2015). Where there was lack of clarity regarding a potential participant's potential eligibility, this was discussed with day centre staff.○ Carers of attenders lacking capacity to consent/with high levels of cognitive impairment○ Potential attendee/volunteer participants with communication needs related to hearing impairments or other disabilities or who do not speak English and are unable to bring a support person to the interview. Efforts were made to be as inclusive as possible by offering the opportunity for paired interviews where communication assistance was needed or potential participants wish for other support and using showcards in interviews.

Key to recruitment of attenders and day centre staff and volunteers were regular day centre visits which aimed to fulfil five purposes. The first was to acquire familiarity with potential day centre participants and to build rapport potentially leading to maximum recruitment and data rich interviews in which response bias would be minimised. Building trust and a rapport is essential to appreciating a setting and deconstructing a researcher's preconceptions (Lincoln and Guba 1985). The second was to speak about the research and answer questions about it. The third was to actively recruit participants, arrange and undertake interviews. The fourth was to gather data about the day centres that would contribute to the case studies. Thus, potential participants were being informed and reassured that taking part in the study was voluntary and unrelated to the provision of the service itself. The last was to minimise the cost and time burden for participants by being available in person for a whole day. This approach is in line with McHenry *et al.*'s (2015) findings that successful recruitment of older people is rooted in cultivating relationships with organisations and face-to-face contact with potential participants.

3.3.2 Day centres

Potential day centre case studies were identified purposively by investigating what was available in different areas by reading online local older people's service directories, local authority websites, web pages of known providers and by using search engines. This was undertaken with reference to the typology of day centres (see Figure 2 in section 3.2.2). After identifying and mapping a selection of day centres onto the typology, I telephoned contacts of first preference day centres outlining the research and inviting them to discuss this in person with a view to participating. These meetings also enabled further evaluation of day centres' suitability. I approached local authorities directly about local authority-run day centres. Initial approaches were made prior to ethics approval following advice to name potential authorities on the application.

After ethics approval and agreement had been given for a day centre to participate, I confirmed this in writing, stating that participation was subject to local authority agreement to participate and Research Governance approval being granted. I then approached the local authority about potential participation before formally applying for local Research Governance approval. Participation was confirmed with day centre managers after this had been received. Section 3.6 covers ethics and Research Governance.

All commercially-run day centres identified were found to specialise in care of people with dementia. Of the local authorities approached about the participation of one of their day centres, one rejected participation due to restructuring plans. A change of circumstances meant another standalone local authority-run day centre was unable participate despite initial agreement. Both voluntary sector day centres approached agreed to participate via the organisational manager,

one of whom also managed the day centre; the latter also required attendance at a committee meeting of the local organisation to gain its approval. The remaining day centre manager required approval from both their manager and a local authority commissioner prior to agreeing to participate. Four day centres were recruited.

3.3.3 Individual participant groups

The following sub-sections particularise selection and recruitment of attenders, carers, centre staff, volunteers and managers and local authority staff, and the challenges thereof. Consent was discussed and informed consent given immediately before interviews with all individual participants.

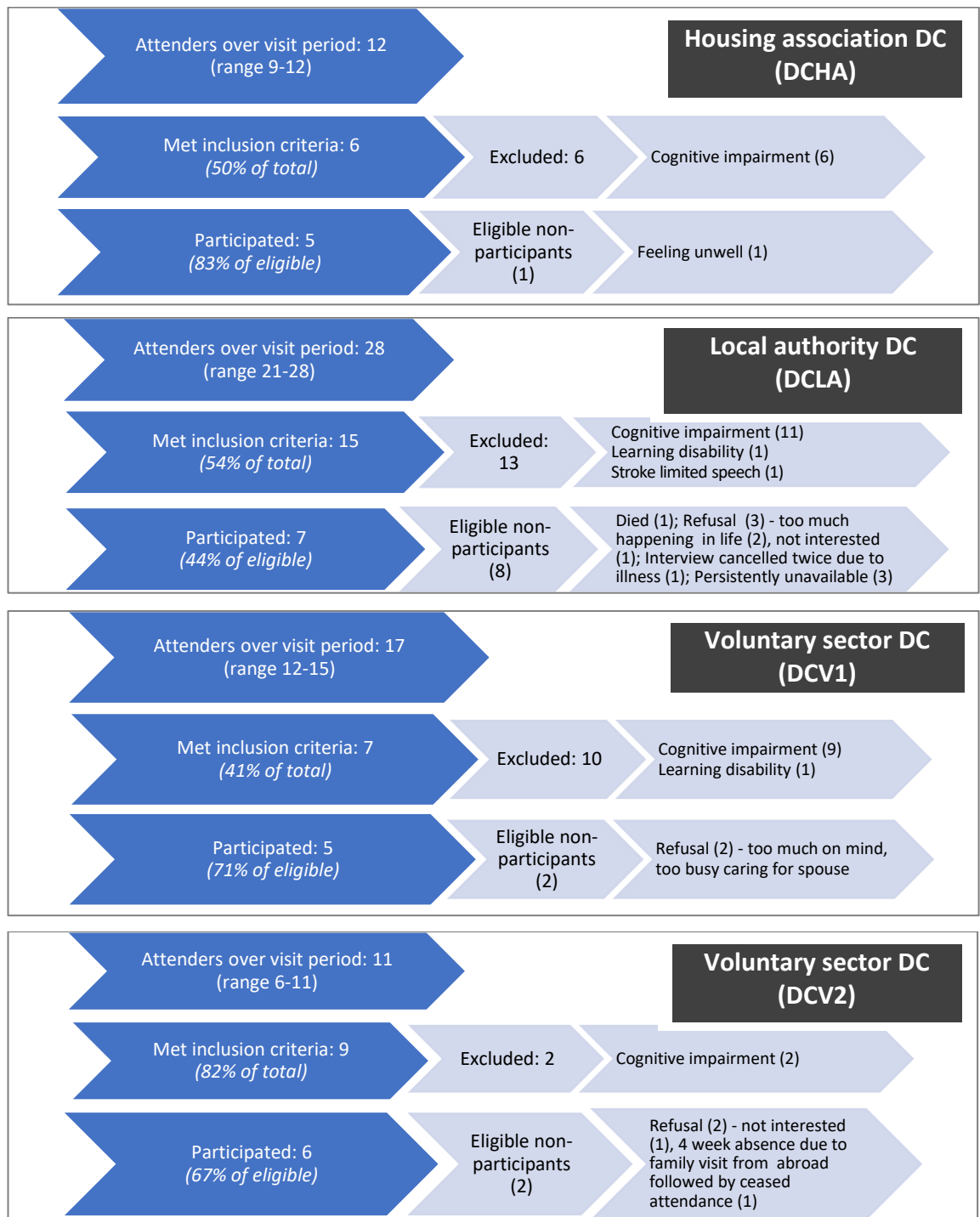
Older attenders

Attender participants were a convenience sample recruited during regular visits to day centres. After discussing which attenders would meet the inclusion criteria with managers and/or staff, I distributed Information Sheets, explaining that they were about my research. Time lapses between giving these to potential participants and asking about participation varied and were based on personal judgement, responsiveness and opportunity. Sometimes, for example, there were limited times at which to have a private conversation about participation due to room layout, organised activities or because I was busy speaking to another attender, staff or volunteer. Alternatively, some attenders were feeling unwell, had problems or were absent for some weeks.

Just over half (n=37, 54%) of all attenders observed to attend the four centres during the visit period (n=68) met the inclusion criteria while the remainder did not (n=31, 46%) (see Figure 4). Proportions of eligible attenders ranged from 41-82 per cent. Of those eligible, almost two thirds (n=23 of 37, 62%) participated in the study, equating to one third of all observed attenders (n=23 of 68, 34%). Non-participation of those eligible (n=14 of 37 eligible, 38%) resulted from refusal to participate (n=8), persistent unavailability¹ (n=4), illness (n=1) and death (n=1).

¹ Persistent unavailability covers being apparently willing, but always busy or not present, or too busy to discuss the study, very infrequent attendance and extended absence followed by a decision to cease attending.

Figure 4: Recruitment of older attenders



There were more attenders with higher levels of cognitive impairment than indicated to me by managers at initial contact, perhaps exacerbated by time lapses before visit periods, particularly in DCHA. Cognitive impairment was the main reason for exclusion (n=28, 90% of those excluded, 41% of all observed attenders).

Family carers

Overall, there were lower numbers of potential carer participants than hoped for. This was due to lower numbers than expected of attenders meeting inclusion criteria and because two centres targeted socially isolated people.

Managers were consulted about how best to identify and contact carers and different methods were employed. At the first centre, to maintain potential participants' confidentiality, a letter, co-signed by myself and the manager, was posted by the centre to family members identified by the manager using centre records, and telephone follow-up was undertaken by staff. After feedback from the first carer interviewed, a revised and shortened version was used at other centres.

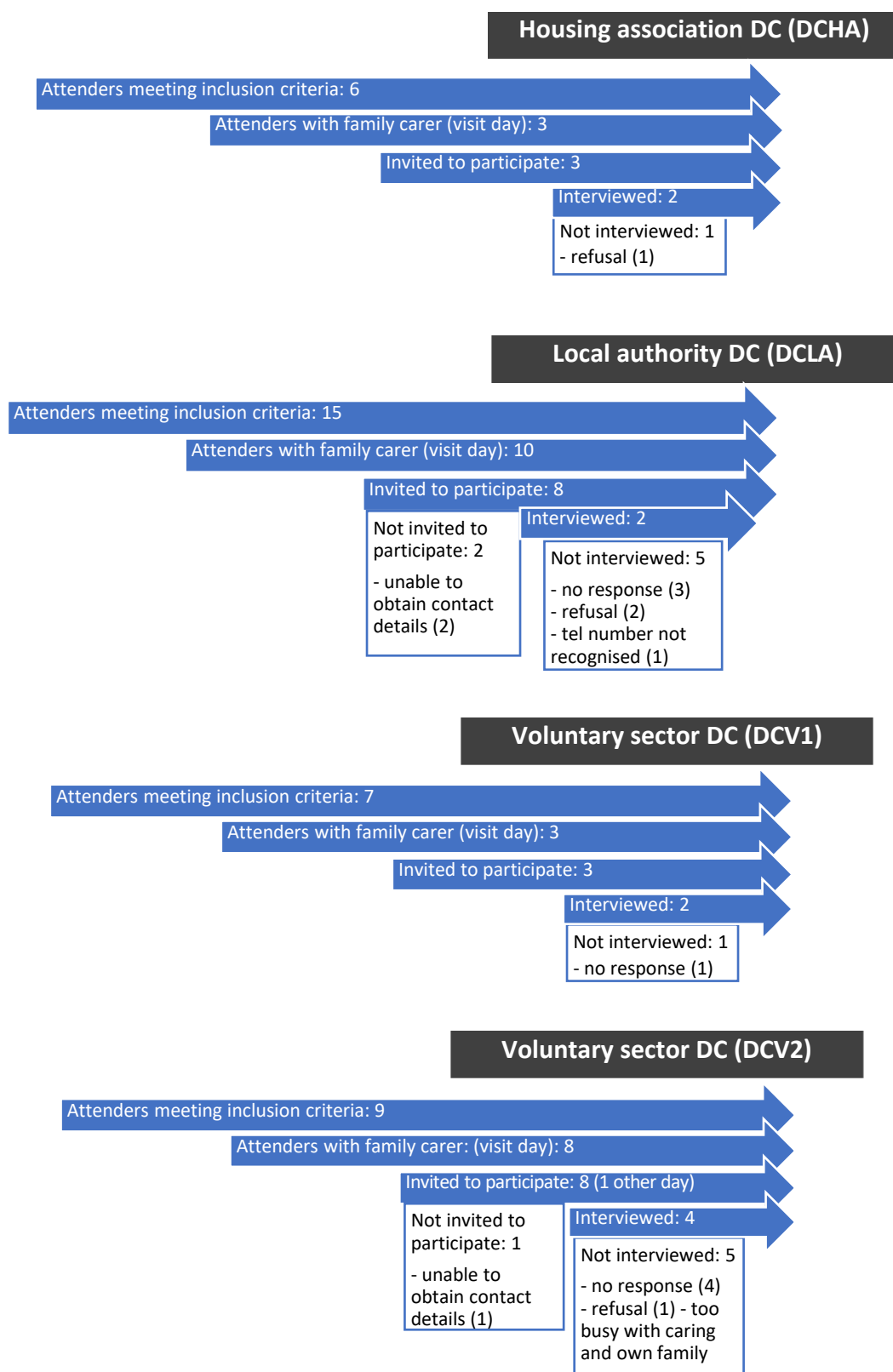
'Family member' was used instead of 'carer' which was reported to imply 'paid care worker', and it clarified that receiving Carer's Allowance did not exclude people. At the second centre, letters were posted to emergency contacts identified by staff from centre records. At the third and fourth, I asked attenders to whom letters could be sent, after being advised whom not to ask due to having estranged or no family. Some provided names and addresses; others gave names and permission for staff to provide addresses from centre records and some declined the request.

Towards the end of the visits to the third centre, despite following up on invitations, only one carer had participated in the study despite having re-sent letters and no contact had been received from potential participants. Consequently, a minor amendment to the ethics approval opened recruitment to carers of attenders on other days. At this stage, I asked attenders of the third centre for family members' telephone numbers and re-visited the first and second centres to do the same, having first gained managerial permission. Meeting carers improved recruitment; three of the four I met, at attender interviews or after they had dropped off a relative at a centre, participated.

Carer recruitment (n=10) is shown in Figure 5. The DCHA visit day was the operational day with the most cognitively able and the largest number of attenders; the only potentially eligible attender attending on another day did not have a carer. At DCLA, staff said they only knew if a contact was a carer if an attender had informed them of this. Only one carer, whom I had met while interviewing her relative, and who had agreed to participate after dropping them off at the centre, was recruited for DCV1 in the first round. At second approach, nine months later, one

attender with a carer had left and the remaining one participated. Many attenders at DCV2 also attended the other day of operation and only one more met the inclusion criteria.

Figure 5: Recruitment of family carers



Day centre staff, volunteers and managers

Managers had already agreed to participate at initial approach. Staff and volunteer participants were a convenience sample recruited during regular visits to centres in the same way as attenders.

Participation levels were high (see Figure 6). Since there were fewer volunteers than expected at DCLA and DCV2 and, none at DCHA, I later returned to DCV1 and recruited further volunteers (n=2) to balance numbers.

Figure 6: Recruitment of day centre managers, frontline staff and volunteers

Type of participant	DCHA	DCLA	DCV1	DCV2	Totals
Managers	2 (Manager on secondment and interim manager)	1	1	2 (Provider manager and centre manager)	6
Staff	4 of 5 (1 off sick for extended period)	3 of 3	1	2 of 2	10
Volunteers	0 of 0	1 of 1	5 (weekly numbers varied): 4 regular frontline + 1 dual role. - 4 regular frontline volunteers - 3 in dual roles (frontline & kitchen) (2 with learning disability excluded on manager's advice) - Rota of chefs, some of whom also stayed for afternoon - Discovered afterwards that additional volunteer was a 'conversation volunteer' not a member.	1 of 1	7
Totals	6	5	7	5	23

Local authority professionals

The sample of professionals was originally to include at least one commissioner or signposter/referrer working in social care and one in the NHS. Delays in receiving local authority Research Governance approvals led to a delay in being ready to seek NHS Research Governance in order to approach GP surgeries. At the same time, the Health Research Authority (HRA) approval system also changed considerably leading to difficulties for applicants and backlogs. These led to a decision not to apply for NHS Research Governance approval. Since health professionals were not to be in the sample, a revised aim was to try to ensure that at least one referrer/signposter in each local authority area was from a health/clinical background (e.g. occupational therapy) to complement the social care perspectives.

Local authority participants (see Table 1) were identified using snowballing techniques, mainly through the commissioners with whom initial, informal contact had been made about

participation. Commissioner recruitment was relatively straightforward, if time-consuming due to their higher-priority work necessitating multiple contacts allowing for reasonable delay.

Recruitment of frontline social care staff was more challenging in all areas, despite commissioner support, and was achieved due to persistence and determination. None were recruited for DCV1, reportedly for reasons of time constraint and staff shortages. I encountered the problem of exhausting initial contacts and false starts when trying to identify new chains, identified by Biernacki and Waldorf (1981). For example, one authority was undergoing restructuring which resulted in difficulties identifying contact people and another had multiple teams. Furthermore, given the willingness encountered to participate among frontline staff themselves once accessed, managerial gatekeeping was evident, with some managers unwilling to circulate information or provide contact details of appropriate staff. Other methods used to recruit this group were meeting attendance, contacting the Head of Adult Social Care and obtaining contact details from centre managers. A further difficulty concerned maintaining the confidentiality of participating centres, the identity of which was revealed only after participants had signed consent forms. This meant that signposters/referrers were not all familiar with participating centres.

Regrettably, no referrers/signposters with a health/clinical background were recruited. Therefore, this thesis does not include the perspectives of health service commissioners and signposters/referrers or the perspectives of primary care health professionals.

Table 1: Recruitment of local authority staff

Type of participant	DCHA	DCLA	DCV1	DCV2	Totals
Commissioners	1	1	2	1	5
Signposters / referrers	2	3	-	3	8
Totals	3	4	2	4	13

3.4 Conduct of fieldwork

This section provides an overview of fieldwork, then describes and discusses the methods and tools employed in data collection.

3.4.1 Overview of fieldwork

Fieldwork consisted of weekly visits to four day centres and individual, face-to-face semi-structured interviews with attenders, carers, staff, volunteers and managers of centres and local authority employees working in social care. I administered validated tools in some of the questions I asked attenders and carers.

By way of contribution acknowledgement, attenders, carers and centre staff and volunteers were given certificates of participation in research, and day centres were each presented with a certificate and a donation of £100 on my last visit (see Appendix 10 for copies of certificates). Managers were made aware a donation would be forthcoming, but the amount was not disclosed. Presenting a certificate and donation to centres was a strategy intended to allow all at the centres to feel appreciated and part of a research project, not just the participants.

3.4.2 Weekly day centre visits

Weekly visits to centres (see Section 3.3.1) took place between 16 September 2015 and 14 October 2016, and interviews over 15 months (October 2015-December 2016). The first day centre acted as a pilot, after which it was decided, first, to undertake fieldwork at centres consecutively to ensure sufficient free time for interviews and recruitment of other participant groups and, second, to extend visit periods from 12 to 14 weeks, to allow more time to get to know attenders before distributing Information Sheets. Thus, 56 days were spent at the four participating day centres.

During visits, as well as building relationships and recruiting participants, I made diary notes and collected documentation such as activity programmes and newsletters with which to build descriptions. To minimise any adverse impact my presence may have, to build rapport and become familiar with potential participants, I joined in activities, ate lunch with attenders and provided assistance where appropriate. My clothing choices reflected what I believed attenders' age group would consider respectable.

3.4.3 The choice of interviews for data collection and data gathered

In-depth interviews allow access to data which cannot be gained by observation (Minichiello *et al.* 1990), to explore and gain understanding of, for example, actions (Minichiello *et al.* 1990), lived experiences (Seidman 2013), views (Ritchie and Lewis 2014) and understanding or interpretation of events (Ritchie and Lewis 2014).

An individual, face-to-face approach to data collection was selected over focus groups. Although focus groups may be helpful for exploring opinions and concerns (Kitzinger and Barbour 1999) and can generate rich data (Bryman 2012) and valuable insights (Berg and Lune 2012), group discussions may have presented difficulties for participants with hearing or communication difficulties. Group data collection would have presented challenges for the contextualisation of individual experiences, some of which may not have been disclosed if private, thus the in-depth exploration required by the research questions may have remained inadequately addressed.

Self-completion questionnaires were rejected as they are likely to be problematic for older people with sight impairments and hand mobility problems, particularly when questions aim to elicit rich data which may need exploration. Findings of broader surveys would be likely to be unrepresentative since no central register of day centres exists.

Table 2 summarises data collected in interviews. Full interview schedules, tested with the Study Advisory Group appear in Appendix 8.

Table 2: Interview topics and validated scales by participant group

Older attenders		What a 'usual week' looks like; how/why they started attending day centre; their experiences of and views on it; outcomes; socio-demographic data. Validated tools collected data on wellbeing, health status, social networks and Social Care Related Quality of Life.
Carers		Relationship with the day centre; any benefits they get from the person they care for attending it; outcomes they think attenders experience; socio-demographic data. Validated tools collected data on wellbeing and Social Care Related Quality of Life.
Day centre staff and volunteers	Frontline staff and volunteers	Involvement with day centre; outcomes of volunteering/working there; views of outcomes for attenders and socio-demographic data.
	Managers, trustees, owners	The service they believed the day centre offered; how they saw its fit within the market of social care; its funding and attenders; relationships with local health services; any plans for the future; background information; attender data held by day centres and how used; anonymous, aggregate data about attenders, if possible.
Local authority professionals	Commissioners	Perspectives of the role and purpose of day centres and their fit within the health and social care market; whether they commissioned any and why/why not; views on what attender data day centres could collect that may help commissioning decisions.
	Signposters/referrers	Perspectives of the role and purpose of day centres and their fit within the health and social care market; whether they signposted/referred to day centres.

All participant groups, except attenders, were interviewed once. Two interviews were scheduled for attenders, but most opted to continue with the second, shorter one, immediately after the first. Twenty-nine interviews were undertaken with 23 attenders. The qualitative parts of all interviews were held in private spaces (e.g. meeting rooms, hairdressing salon) (n=7) or in their homes (n=16). To express appreciation for allowing a home visit, attenders and carers (n=10) interviewed in their homes were taken home-baked biscuits or flowers. All expressed being impressed, grateful or moved by this effort. All except three staff and volunteers were interviewed in private spaces at centres; others were interviewed at home.

3.4.4 Use of validated scales and data gathered

Validated scales were employed to collect data about attenders' well-being (SWEMWBS), frailty/health (EFS) and social support networks (PANT), and carers' wellbeing (SWEMWBS), thus addressing the second research question by describing the participant sample. A validated cost-utility scale (ASCOT) was used to measure attenders' and carers' Social Care-Related Quality of Life (SCRQoL) outcomes related to day centre attendance. These scales appear in Appendix 3. In

addition to providing descriptive data, the use of these tools aimed to test whether collecting data about attenders using standardised measures might be feasible for day centres, potentially forming a useful and robust evidence base for their own use. They were selected due to their potential suitability for these purposes. Their use is covered in Chapter 7.

Use of the SWEMWBS, ASCOT and EFS is subject to permission, which was successfully sought, and their use registered. I underwent ASCOT INT4 training and obtained the training pack for PANT (Wenger 1994). ASCOT-INT4 Carers had not yet been released for public use, but its developer granted permission for its use.

The following sub-sections summarise the main features, strengths and weaknesses and scoring of the scales used.

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

Changes in individual wellbeing could be measured as an indicator of service impact and may be useful for monitoring purposes. This 7-item scale was developed to enable the monitoring of subjective mental wellbeing and evaluating programmes which could influence this (NHS Health Scotland *et al.* 2008)². Validated for self-completion, it measures mental wellbeing (i.e. feeling and functioning not illness and disorder) using positively-worded statements. Scores are transformed enabling it to be used as an interval scale for psychometric analysis. Although the '*SWEMWBS presents a more restricted view of mental well-being than the 14 item WEMWBS, with most items representing aspects of psychological and eudemonic well-being, and few covering hedonic well-being or affect. However, robust measurement properties combined with brevity make SWEMWBS preferable to WEMWBS at present for monitoring mental well-being in populations*' (Stewart-Brown *et al.* 2009:1). It has also undergone a more rigorous test for internal consistency than 14 item scale and has superior scaling properties. Given its brevity, the 7-item version was considered more likely to be employable in day centre settings than the 14-item version.

Raw scores range from 7-35 and metric (transformed) scores from 7.00-35.00, with higher scores indicating higher levels of wellbeing. Over one standard deviation above the mean indicates good mental wellbeing; a score of more than one standard deviation below the mean indicates poor mental wellbeing; within one standard deviation of the mean indicates average wellbeing (Taggart *et al.* 2015).

² The Warwick-Edinburgh Mental Well-being Scale was funded by the Scottish Government National Programme for Improving Mental Health and Well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh.

However, the SWEMWBS was only validated for use with people aged 13-74 years (Taggart *et al.* 2015) and day centre attenders are likely to be older. Although validated for some ethnic backgrounds and its use is encouraged for all ethnicities, it has not been validated with Black or Afro-Caribbean groups (Taggart *et al.* 2015). Sensitivity to change has been tested in the 14-item but not the 7-item version (Taggart *et al.* 2015). Its robustness is untested when reading out items or completing unseen (Taggart *et al.* 2015).

Edmonton Frail Scale (EFS)

Although there is no consensus on the definition of frail (de Vries *et al.* 2011), frailty is associated with adverse health outcomes (Clegg *et al.* 2013). Despite the label of 'frailty' being interpreted negatively by older people who feel it undermines their resilience (Nicholson *et al.* 2017), identifying frailty levels can assist care planning (Rockwood *et al.* 2015) and, when combined with other data, may be useful for monitoring purposes.

An objective screening tool, the EFS reflects the multi-dimensional, unstable and heterogeneous nature of frailty (Rolfson *et al.* 2006). Nine questions on general health, functional independence, social support, medication use, nutrition, mood, continence are supplemented by the clock-drawing test, for cognition, and the Timed Up and Go (TUG) test for functional performance. Scores range from 0-17, with higher scores indicating greater frailty. Scores are converted to categories: No frailty (0-4), Apparently vulnerable (5-6), Mild frailty (7-8), Moderate frailty (9-10) and Severe frailty (≥ 11).

The EFS was selected as it was considered to include the most current concepts of frailty, because it includes social support, has been tested with older people (mean age 80.4 years) and validated as a reliable and feasible tool for use by non-geriatricians (Rolfson *et al.* 2006). As a short tool, its use is potentially feasible in day centres. However, reliability is potentially compromised by recall error and it is not a 'gold standard' clinical assessment tool (Rolfson *et al.* 2006), providing data for descriptive use only.

A study published after data was collected for this thesis found EFS to be significantly associated with other tools used to collect data on specific areas of frailty, and concluded it was '*cheap and convenient (...) to assess frailty upon hospital admission*' (Perna *et al.* 2017).

Practitioner Assessment of Network Type (PANT)

This objective tool was developed to measure social support networks in populations aged 50 or older (Wenger 1994). People may fall into one of five network types or there may be overlap between these: Locally Integrated, Wider Community-focused, Locally Self-Contained, local Family-Dependent and Private Restricted support network. Since each type is associated with

specific problems and the likelihood of need for formal services can be predicted based on network typology (Wenger 1994), this tool may be of interest to day centres for monitoring purposes.

With only eight questions, it is easy to use and non-intrusive (Wenger and Tucker 2001). However, unlike other tools, such as LSNS-6 which screens for social isolation (Lubben *et al.* 2006), PANT does not measure quality of support or relationships. It measures level and frequency of contact and physical distance but not types of contact as it was developed before internet-based communication was commonplace (Stephens *et al.* 2014). At the start of the present study (2015), a project to update PANT was starting at the University of Swansea.

Adult Social Care Outcomes Toolkit (ASCOT)

This validated scale measures subjective Social Care Related Quality of Life (SCRQoL) or the relative value of services to the individual (Caiels *et al.* 2010) which enables fairer comparison of effectiveness between services. Funded by HM Treasury's 'Invest to Save' Budget, it aimed to encourage *'more efficient and effective commissioning and procurement of services, placing the issues of quality and value for money at the heart of the decision-making process'* (Caiels *et al.* 2010:2) and to facilitate outcomes-based commissioning of public services, particularly 'low level' ones which were considered to *'have a 'preventative effect', that is, rather than just helping people to overcome impairment and need, they help delay the onset of greater need by encouraging people to stay independent and giving people the confidence to undertake activities of daily living by themselves'* (Caiels *et al.* 2010:2). Therefore, it focused on measuring services' impact on the more intangible aspects of quality of life.

There are several versions. This study used INT4 which is designed for face-to-face use. One strength, and the reason this study is using it, is that it is used at one time point to measure current SCRQoL and expected SCRQoL in the absence of service where nothing takes its place. This enables comparisons to be made and SCRQoL gain (or capacity to benefit) scores, which indicate service impact on quality of life, to be calculated by deducting expected from current scores. Answers divide needs into high needs, some needs, no needs and ideal state.

The local authority Adult Social Care Survey (ASCS) gathers quality of life data using a different eight-question version of ASCOT. ASCOT INT4 current quality of life scores are comparable with data gathered by the ASCS provided that aggregate, non-preference-weighted scores are calculated. However, publicly-available data are not separated by age groups and service type. Data from this study have not been compared since gaining access to the detailed data would have entailed gaining a data-sharing agreement and ethical approval.

ASCOT INT4 (v3.3) – used with attenders

This is a subjective multi-domain, cost-utility social care-related quality of life measure (Netten *et al.* 2011). It has 23 questions, in eight domains (see Box 2), with filter questions potentially reducing these to 16. Scores are preference-weighted based on responses to a Best-Worst scaling approach and a time trade-off exercise tested with non-service using members of the public and service users (Netten *et al.* 2012). Thus, greater weight is given to domains people have reported as most important. The higher the gain score, the bigger a difference a service or set of services makes to SCRQoL. Scores may range from -0.17 to 1, where less than 0 is worse than dead, 0 is the equivalent of being dead and 1 is an ideal situation.

Box 2: ASCOT INT4 domains

ASCOT INT4 Domains (summarised from Netten *et al.* 2011:3)

- 1) *Accommodation cleanliness and comfort*: feels their home environment, including all rooms, is clean & comfortable
- 2) *Personal cleanliness and comfort*: feels he/she is personally clean and comfortable and looks presentable or, at best, is dressed & groomed in a way that reflects his/her personal preferences
- 3) *Food and drink*: feels he/she has a nutritious, varied & culturally appropriate diet with enough food & drink that he/she enjoys at regular & timely intervals
- 4) *Personal safety*: feels safe and secure, meaning being free from fear of abuse, falling or other physical harm both inside and outside the house
- 5) *Social participation and involvement*: feels content with their social situation, where this means sustenance of meaningful relationships with friends, family and feeling involved or part of a community should this be important
- 6) *Occupation*: is sufficiently occupied in a range of meaningful activities
- 7) *Control*: can choose what to do and when to do it, having control over his/her daily life and activities
- 8) *Dignity*: negative and positive psychological impact of support and care on personal sense of significance.

It is applicable across wide a range of user groups and care and support settings and has been tested for validity and reliability in older people's day centres (Caiels *et al.* 2010). Its subjective nature and preference weightings mean greater validity in measuring the effects of social care services than EQ5D (Forder and Caiels 2011). It is more sensitive to low needs than the three-level version (Netten *et al.* 2011) and has good construct validity with older people (Malley *et al.* 2012). Cost-effectiveness can be ascertained from gain scores if service costs are known. However, as questions and answer options are wordy and it takes time to administer, there is potential for respondent fatigue despite evidence of feasibility for use with older people. A further point to note is that it was designed for use with older people in receipt of wholly or partially publicly-funded services (Caiels *et al.* 2010) and participants in this study were expected to be a mix of publicly-funded and self-funded. However, all cases study sites were known to be either partially or wholly publicly-funded.

ASCOT INT4 Carer (v1) – used with carers

This is a subjective multi-domain, social care related quality of life measure (Rand *et al.* 2015). It has 21 questions, in seven domains (see Box 3), with filter questions potentially reducing these to 14. Unlike INT4, scores are not yet preference-weighted (Rand *et al.* 2015) but are an aggregate of the domain. Individual scores may range from 0-21, where greater need is indicated by higher scores, and overall scores are expressed as a percentage of the total possible score. The higher the gain score, the bigger a difference day centre attendance made to SCRQoL. It been tested for reliability and validity with carers of publicly funded social care service users (Rand *et al.* 2015).

Box 3: ASCOT INT4 Carer domains

ASCOT INT4 Carer Domains (summarised from Rand *et al.* 2015:2603)

- 1) *Occupation*: is sufficiently occupied in a range of meaningful, enjoyable activities
- 2) *Control over daily life*: can choose what to do and when to do it, having control over his/her daily life and activities
- 3) *Self-care*: feels able to look after him/herself, in terms of eating well and getting enough sleep
- 4) *Personal safety*: feels safe and secure, where concerns about safety can include fear of abuse or other physical harm or accidents, which may arise as a result of caring
- 5) *Social participation*: feels content with their social situation, where this includes sustenance of meaningful relationships with friends, family and feeling involved and part of their community
- 6) *Space and time to be yourself*: having space and time in everyday life; enough time away from caring to have a life of their own outside of the caring role
- 7) *Feeling supported or encouraged*: by professionals, care workers and others, in their role as a carer.

3.5 Data analysis and management

This section details how analysis was undertaken, how data were managed and the rationale for how data are presented. It is recognised that techniques for analysing case study evidence are flexible as each case study may differ somewhat (Yin 2014). This thesis takes a thematic approach within a social policy lens.

3.5.1 Qualitative data analysis

Interview

Analysis of qualitative interview data was thematic (Boyatzis 1998), an appropriate approach for analysing both in depth and exploratory interview data (Ritchie and Lewis 2014) as it captures the intricacies of meaning (Guest 2012).

Interview recordings, totalling 49 hours and 10 minutes, were transcribed professionally using intelligent verbatim method whereby unnecessary sounds or words such as ‘erm’, and short pauses were edited out. The transcriber was provided with interview schedules. To enable immersion and familiarisation with the data, as soon as possible after interviews, I corrected,

added emphasis to reflect intonation and anonymised transcripts while listening to the audio recordings. Of note in the transcripts was the considerable number of incorrectly transcribed words, some of which reversed a sentence's meaning, and important omissions (in some cases of whole sentences), despite difficult parts of recordings having been deciphered. These reflect two of the common issues arising in a small study of university transcribers (Tilley and Powick 2002). While reviewing the transcripts, I noted down emerging codes by hand under research question and interview question headings.

Thematic codes were inductive. Although initial plans had been to build on high-level deductive codes based on literature review findings, the framework was data-driven (Boyatzis 1998). Having grouped handwritten code lists into thematic codes and sub-codes, under each research question, and entered this initial coding frame into Computer Assisted Qualitative Data Analysis Software (CAQDAS), I undertook lumpner coding of data (Saldana 2016) in several cycles. After first coding data to research and interview questions and, second, to initial thematic code heading, I reviewed the data under each of these. In this third cycle, I coded to sub-codes while adding, amending, merging and deleting these as the need emerged, re-reviewing already-coded transcripts at each change and combining thematic codes into overarching themes. For example, word searches were undertaken (e.g. enjoy) where a new sub-theme appeared to be emerging. Thus, the cycle was repeated. Text was simultaneously coded if sections were relevant to more than one code (Miles *et al.* 2014). I developed a coding system to ensure consistency of use and to validate codes used. This was fluid in nature, changing as I refined my thinking. Qualitative data coding was undertaken after calculating ASCOT scores, yet that ASCOT domains did not influence decisions about qualitative outcome themes is less evident in attenders' themes. Appendix 12 displays illustrative examples of coding frames showing how, for example, 'social interaction/companionship' (similar to an ASCOT domain) emerged as a theme. In presenting it (see 8.4.2), I refer to companionship, but selected 'social interaction' as the descriptor to minimise potential for misinterpretation of companionship as encompassing emotionally meaningful friendships that extended beyond day centres, which was not a finding.

Being an CAQDAS novice, I started by coding carers' transcripts as these were the smallest group (n=10), thinking this would be more time-efficient than starting with a larger group of data. I later recognised that previous experience categorising data and designing categories and sub-categories in databases had benefited me and informed my approach.

Maps of the week

Attenders' 'maps of the week' provided rich data to supplement socio-demographic and health characteristics and contextualise centre attendance. As such data have not previously formed part

of research studies of day centres, these 'maps' are a finding of this study. An intention was to analyse these for patterns, but a decision was taken not to do so due to small numbers. A summary overview of 'maps' appears in Chapter 7 and illustrative examples in Appendix 13.

Diary notes

Diary notes (handwritten and later typed up into 72 pages) covered potential participants, attendance, incidents of note, interview plans, notes about day centre operations and my own musings. They also provided valuable reminders to support interviews. Before interviews, I reviewed notes and recorded anything to bring up for discussion under specific questions in case interviewees did not mention something relevant that they had said previously or which I had noticed. As well as contributing to day centre case studies, notes were a reference tool during analysis, and occasionally provided examples to reinforce themes arising during analysis.

3.5.2 Validated tools

Validated scale (EFS, PANT, SWEMWB) and socio-demographic data contributed to descriptions of participants' characteristics (see Chapter 7) and enabled interrogation of data within participant groups. ASCOT findings addressed the outcomes of attendance and are presented alongside qualitative findings in Chapters 8 and 9.

3.5.3 Data management, interrogation, interpretation and presentation

Diary notes and other data gathered were stored systematically in a password-protected Microsoft Office database. All data were processed as soon as possible after each interview.

'Maps of the week' were typed up in MS Excel and colour-coded by type of activity.

Interview transcripts and quantitative data were entered into CAQDAS packages:

- NVIVO (version 11) (NVivo 2015)
- an SPSS syntax file to compute the PANT network type provided by the University of Swansea (Wenger and Scott 1994, 1996)
- two Microsoft Excel data entry tools developed for ASCOT (PSSRU undated-b, undated-a) which calculated ASCOT scores and generated charts.

Attributes collected in interviews (e.g. socio-demographics, centre attended) and validated scale scores were assigned to participants' NVIVO records to enable interrogation of data by day centre, type of participant and participant sub-groups (Saldana 2016).

Cross-case analyses of individual participant group data were undertaken. Although the original intention was to analyse groups within each day centre separately, smaller than planned sample sizes meant this would have been impractical, made drawing conclusions difficult and potentially further compromised participants' anonymity. However, since central cross-cutting themes were

identified across the different day centre cases and participant sub-groups (Ritchie *et al.* 2014), individual day centre analysis was rendered less relevant. Differences between outcomes experienced across centres or by individual attributes are, therefore, not examined, although attention is drawn to some differences among attenders and between centres. To maximise anonymity, comments about specific day centres, or people in them, have been redacted and pseudonyms and participant reference numbers do not state which centre participants are associated with. Attenders and carers were treated separately, not as dyads.

Mixed methods data presentation is potentially problematic (Bryman 1988), affected, for example, by researcher expertise, a lack of best practice examples and word limits (Bryman 2007, Teddlie and Tashakkori 2012). While *'making numerical or quasi-numerical statements'* about qualitative data is usually avoided (White *et al.* 2014), one way of integrating data, used here, is to quantitize qualitative data and present it alongside quantitative data in tables (Sandelowski *et al.* 2009), which enables comparison and triangulation of findings (Plano Clark 2010) and is helpful for length restrictions (Stange *et al.* 2006). By presenting scale of theme emergence, I endeavour to build trust in the qualitative among those with a quantitative preference and contribute to overturning the acknowledged *'perception among research funding agencies, clinicians and policy makers, that qualitative research is 'second class' research'* (Tong *et al.* 2007:356). The order of data in Chapters 8 and 9 was selected to improve flow by enabling introduction of all themes at the start. Separate explanation and presentation of ASCOT findings were felt necessary, appearing before qualitative findings as they are briefer and more straightforward than the latter which were in two parts. As customary, qualitative findings include participant quotations to illustrate qualitative themes (White *et al.* 2014) which adds *'transparency and trustworthiness'* to findings (Côté and Turgeon 2005).

An integral part of the case study is the theory, lens or criteria through which it is viewed during analysis (Thomas 2011, Yin 2014). Social care policy perspectives underpin this study (see Chapter 2).

3.6 Ethical and Research Governance considerations

This section details ethical and Research Governance approvals granted, identifies the key ethical considerations for this study and outlines measures taken to mitigate these risks and other risk-reducing measures.

3.6.1 Ethical and Research Governance approvals

Ethical approval for the research was granted by the Health Research Authority's (HRA) Social Care Research Ethics Committee (ref 15/IEC08/0033) in May 2015. The required revisions to documentation were approved in June 2015 (see Appendix 1).

Following ethical approval, local authority Research Governance approvals were sought. Research Governance Guidance (ADASS Research Group 2014) issued by the Association of Directors of Adult Social Services (ADASS) requires research proposals involving four or more social services departments to be submitted to its Research Group for appraisal. However, a decision was taken to approach each local authority individually since this study sample was to include a maximum of four day centres and, therefore, was on the borderline as fewer than four may have participated. One authority drew attention to this, but did not consider being approached individually to be a problem. Local processes involved lodging evidence of ethical approval together with research tools, or the ethics application and approval, with the local authority or submitting a form for committee scrutiny. This was labour-intensive and time-consuming, particularly in one case study site.

As detailed in Section 3.3, NHS Research Governance approvals were not sought following the protracted process of obtaining local authority Research Governance approvals and changes in the national ethics and governance approvals system.

3.6.2 Key ethical considerations and measures adopted to mitigate risks

Five main ethical challenges arose:

1. Informed consent and voluntary participation
2. Confidentiality
3. Disclosure of harm
4. Distress
5. Inconvenience/removal from services.

Informed consent and voluntary participation

Informed consent was sought from all participants (see Appendix 7 for consent forms).

Information Sheets explained the study's purpose, what participation involved and any potential risks (see Appendix 6). They stressed that participation was voluntary, that participants were not required to answer all questions, may stop the interview at any time and could withdraw without giving a reason and retract any information already provided. They affirmed that provision of the day centre service and the centre's future, were not linked with the research and would not be affected by non-participation. This was important as the research took place at a time of social care funding cuts and withdrawal of some service contracts. I discussed the Information Sheet and Consent Form with potential participants, providing the opportunity for questions.

Confidentiality and disclosure of harm

Information Sheets explained that confidentiality would be maintained throughout, except where abuse, harm, professional negligence or criminal behaviour was disclosed or viewed. Any

concerns emerging were to be discussed with the participant, if appropriate, and supervisors prior to action. Although no concerns arose in interviews, I was informed that one carer participant was the subject of a newly reported safeguarding concern. Professionals were asked to keep confidential which centres were participating in the study. The transcriber signed a confidentiality agreement. Data are anonymised and participants' identity will not be revealed in any outputs; pseudonyms are used for attenders and carers, and reference numbers for other participant groups.

Distress

As attenders may have been involved with day centres as a result of loss (e.g. bereavement, declining health) and the interview covered their usual week and reasons for attending day centres, the study was potentially intrusive. Although questions to be asked of attenders and carers were discussed with two Advisory Groups, it was envisaged that some participants may experience distress. Two attenders became distressed and were offered a break, the option of terminating and later resuming the interview, or withdrawing. One continued with no break and the other had a break before resuming the interview. No family carers became visibly distressed. A small number of attenders and carers commented that interviews had been therapeutic and enjoyable. All participating attenders were given information about potentially useful contact organisations (see Appendix 9).

Inconvenience/removal from services

Atenders and/or carers pay to use day centres. Holding interviews on an attendance day may have been construed as obstructing service provision and/or socialising. Atenders were offered the opportunity to choose the time and venue of their interviews.

Other risk-reducing measures taken

Day centres are not regulated by the Care Quality Commission, the social care regulatory body. Atenders, carers and volunteers were potentially vulnerable. I underwent an Enhanced Disclosure and Barring Service (DBS) check, and registered it for annual updating, to reassure managers and potential participants (see Appendix 2).

Where interviews were not undertaken in public buildings, I followed approved protocols on lone working and adult safeguarding and the Social Research Association's Code of Practice for the Safety of Social Researchers [SRA undated]. I shared any anticipated risks, with whom and where the interview would take place, when it was likely to finish and made contact with an agreed party before entering for the interview and after leaving, who could raise the concern should that call not be made. Twice, a lack of mobile phone signal resulted in safety calls to interviewees' home telephones. The KCL Risk Assessment form was also completed and submitted.

The British Society of Gerontology's Ethical Guidelines (BSG 2012) were adhered to in planning this research.

3.7 Literature review

A systematic scoping review of the literature was conducted to determine the levels of existing knowledge relating to the first research question: 'what is already known about the purpose of day centres, how they are perceived, who benefits from them and how?', thus identifying evidence gaps. The sections below justify, describe and discuss the approach taken and detail search strategy, inclusion and exclusion criteria applied, appraisal and data extraction and presentation methods. Chapter 4 presents its findings.

3.7.1 Review type and approach

As Fakis *et al.* classify their systematic review of quantitative analysis of qualitative data as a scoping review '*due to its aim to identify gaps in the literature*' (2013:143), so does this review.

Different approaches are taken to systematic reviewing, but core principles are their use of explicit, rigorous and accountable methods (Gough *et al.* 2012), application of transparent and replicable processes which are set at the start (Campbell Collaboration Undated). In addition to clearly specifying how literature has been found, screened and summarised, this review addresses a clearly defined question or criteria (Gough *et al.* 2012).

Approaches to appraisal for inclusion differ; even within the medical field, '*the use of any quality score can be fraught with difficulty*' (Torgerson 2003:54). After conducting a feasibility study of the potential for systematic reviews of social care interventions, Long *et al.* (2002) highlighted the complexity of undertaking these, concluding that '*that there is useful research literature that can be drawn together in the form of systematic reviews*' (2002:24). As traditional evidence hierarchies favour quantitative evidence (Dixon-Woods *et al.* 2005, Noyes 2010), modification of traditional approaches (Dixon-Woods *et al.* 2005) and context-appropriate appraisal (Noyes 2010) have been advocated for. Not all systematic reviews score papers. Inclusion in Garcia *et al.*'s (2002) systematic review of women's views was based on value to the review question, something argued for by Pawson (2006). Long *et al.* (2002) used different templates to critically appraise qualitative and quantitative literature. Assessment criteria for inclusion in an EPPI-Centre-undertaken systematic review of systematic reviews on social care interventions was use of a comprehensive search strategy and explicit inclusion criteria that were presented in methods sections (Sutcliffe *et al.* 2012). Following these examples, and due the present study's location in social care and the breadth of type of material expected, a strategy combining simple

methodological appraisal and value to the review question was employed to determine inclusion following application of inclusion/exclusion criteria.

Meta-analysis, a usual, but optional component (Campbell Collaboration Undated), was not undertaken as specific intervention results are not being reviewed for effectiveness. Instead, following Gough *et al.* (2012) and integrative review methodology (Whittemore and Knafl 2005), findings of both qualitative and quantitative research are presented in Chapter 4, in a configurative synthesis in which data are organised to answer the review question by identifying themes '*in order to build up a picture of the phenomenon of interest*' (Thomas *et al.* 2012:188).

Although the norm is to conduct systematic reviews in teams (Oliver *et al.* 2012), as an individual doctoral study, papers were not reviewed by multiple reviewers.

3.7.1 Review execution

A three-stage, systematic, comprehensive and sensitive search strategy was used. This aimed to identify as much potentially relevant material as possible, including grey literature, to compensate for publication bias (Burdett *et al.* 2003) and terminological variations, and because it was expected that day centres may not be the main subject of relevant literature.

Searches were undertaken in three phases (see Table 3):

1. Database and library searches.
2. Hand-searches of journals, research repositories and websites of relevance.
3. Weekly Google Scholar alerts and alerts to key journals' contents pages were set up to capture any new literature. In August 2017, these were reviewed and a search of the National Institute for Health and Care Excellence's (NICE) evidence database was also undertaken (NICE is a Non Departmental Public Body providing national guidance and advice to improve health and social care).

Table 3: Literature review search strategy

Phase	Search details
Phase 1 Database and library searches (16-27 Oct 2014)	Bibliographic Databases (12): Applied Social Sciences Index and Abstracts (ASSIA), Cochrane Library, IngentaConnect, JISC Journal Archives, NHS Evidence Search, OCLC FirstSearch - Article First, OvidSP - Social Policy and Practice (includes Centre for Policy on Ageing's database AgeInfo), PubMed, Scopus, Social Services Abstracts, Web of Science Core Collection, Web of Science MedLine Websites/internet search engines: British Library e-theses online service (ETHOS), Open Grey, Social Care Online, WorldCat Dissertations and Theses Libraries: King's College (including PURE research portal), British Library, Senate House
Phase 2 Hand-searched (6-10 Nov 2014)	Websites of relevance, research repositories and journals: Age UK, Brunel Institute for Ageing Studies, DEMOS, Independent Age, Institute for Public Policy Research, Joseph Rowntree Foundation, King's Fund, Lancaster Centre for Ageing Research, National Development Team for Inclusion, National Centre for Social Research, Oxford Institute of Population Ageing, Personal Social Services Research Unit (Manchester), Personal Social Services Research Unit (LSE), ResearchGate, Research into Practice for Adults, Personal Social Services Research Unit (Kent), Sheffield Institute for Studies on Ageing,

	Social Care Workforce Research Unit (SCWRU), Social Science Research Network, Social Policy Research Unit (York), Southampton Centre for Research into Ageing, Swansea Centre for Innovative Ageing Peer-reviewed journals hand-searched: Ageing & Society, The Gerontologist, Health & Social Care in the Community, International Journal of Integrated Care, Quality in Ageing and Older Adults, Research Policy and Planning, Social Policy & Society, Working with Older People
Phase 3 Alerts set up (Nov 2014)	Weekly Google Scholar alert and alerts to tables of contents of above journals and Journal of Applied Gerontology, British Journal of Social Work, Critical Social Policy, Journal of Gerontological Social Work, Geriatrics and Gerontology International, Journal of Integrated Care, Journal of Public Administration, Research and Policy and Sociology of Health and Illness.
Search (Aug 2017)	Search of NICE's evidence database undertaken.

The search focused on:

1. The role, purpose or place of day centres - both individual and broader social care market aspects.
2. Outcomes for older attenders, carers and those working/volunteering in or providing day centres.
3. Perceptions of day centres.

Following testing and further refinement, key words to use in structured searches in Phase 1 were finalised (see Table 4). Results were further narrowed by language, date (2000-2014) and atabase categories.

Table 4: Key words used in structured searches of bibliographic databases

Subject area	Search terms
Older people	Elder/elderly, old/older, aged, senior
<i>AND</i>	
Day care / service / centre	Day centre/er , senior centre/er, day care, day care + care home / nursing home
<i>AND</i>	
Commissioning, referring/signposting, staff/volunteers/managers, role, outcomes, which older people attend	<u>Commissioning</u> : Fund(ing), Commission*, Purchas* <u>Referrers/signposters</u> : Referr*, Signpost* <u>Staff/volunteers/managers</u> : Staff, Volunteer, Manager <u>Carers</u> : Care, Carer, Caregiver, Relative, Family <u>Role / purpose / outcomes</u> : Purpose, Role, Outcome, Impact <u>Which older people?</u> User profile, Attendees, Clients, Clientele, Patients, Service user
<i>NOT</i>	
Exclusions	Child*, Paediatric, Day hospital*, Palliative, Hospice
<i>Where * denotes alternative word endings</i>	

Literature identified was saved in EndNote bibliographic software, de-duplicated, the title and abstract screened for potential relevance (see Table 5), and full-text retrieved if judged potentially relevant and if relevance remained unclear.

Inclusion criteria were revised after screening on title and abstract as a large volume of literature remained. During full text screening, a sizeable international body of literature, including literature reviews, emerged about day centre attenders with dementia and their carers

(Quayhagen *et al.* 2000, Zank and Frank 2002, Gaugler *et al.* 2003a, Gaugler *et al.* 2003b, Woods *et al.* 2006, Gustafsdottir 2011, Zarit *et al.* 2011, Fields *et al.* 2012, Zarit *et al.* 2014). Therefore, remaining studies in which more than approximately one third of samples had dementia were excluded (e.g. 39% in Katz *et al.* 2011) unless findings were relevant and separated from findings about people without dementia (e.g. Kuzuya *et al.* 2012, 2006). This was due to my belief, upheld by my supervisors, that English generalist day centres for older people were unlikely to have more than around one third of service users with dementia. Literature published from 2000-2004 was also excluded since inherent publishing delays meant that findings were likely to be less relevant to the current policy and service situation. Papers concerning a very specific context or population that may not be relevant to generalist day centres in England were also excluded (e.g. service preferences of Japanese American baby boomers compared with older Japanese migrants). Master's degree dissertations retrieved were excluded unless findings had been published and were retrieved.

Table 5: Inclusion and exclusion criteria

	Literature included if:	Literature excluded if:
<i>Population</i>	Related to older people (as specified by day centre/research project /report)	Study participants were people with dementia lacking capacity or their carers*
<i>Intervention</i>	About or related to day centres (defined in 1.5.1 (including in care homes/sheltered housing etc)	About end-of-life/palliative/hospice day centres: these tend to be located in hospices and serve a discrete purpose Day centres for people with dementia* Day centres for homeless people: these are often for all ages, and older homeless people's circumstances and their purpose may vary considerably from those of group being studied.
<i>Language</i>	Published in English	Not published in English
<i>Topics</i>	Explored the role, purpose or place of day centres; outcomes - for attenders, carers and volunteers/staff; or perceptions of day centres (including those of referrers', signposters' and potential commissioners')	Did not address the research questions; Questions addressed but population or context very specific and not relevant to an English study of generalist day centres
<i>Timespan</i>	Published from 2005 up to the search dates (Oct/Nov 2014)*	Published before 2005*
		Could not be retrieved in full.
*After revising inclusion criteria.		

Many documents did not contain abstracts necessitating reading of longer executive summaries. All results of searches were saved and screened during phase one. In phase two, potentially relevant documents were screened at the time of search and only those meeting the inclusion criteria, based on reading the title and abstract, saved.

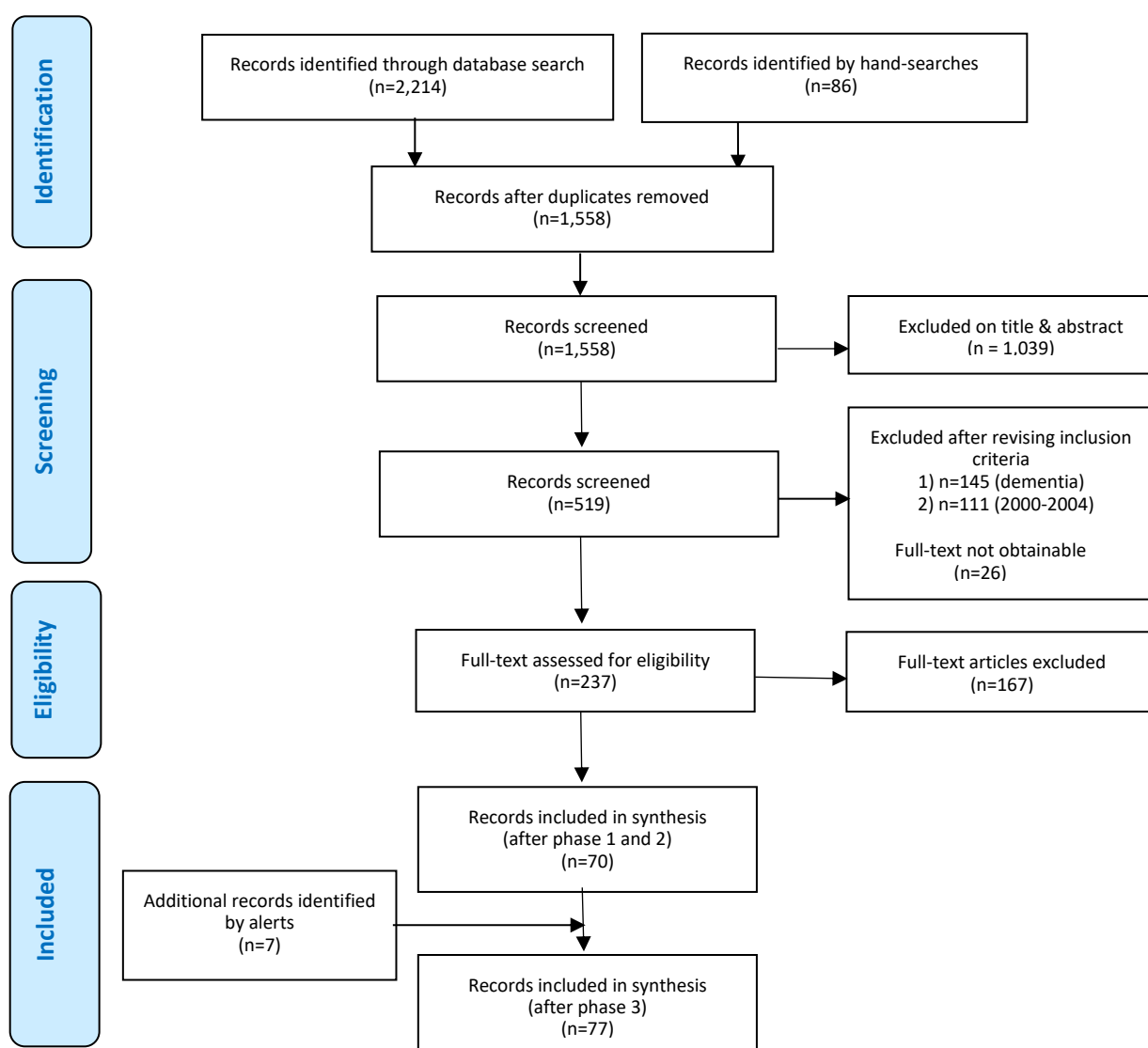
A modified version of the Critical Appraisal Skills Programme's (CASP) three stage approach to appraising evidence, which uses a staged 'yes', 'can't tell', 'no' approach (CASP 2013b, 2013a), was employed. First, the validity of results are evaluated based on whether a clearly focused issue

was considered with an appropriate methodology. If 'yes', then methodological details are considered. Papers considered valid and minimally biased continue to the second and third stages, in which findings are reviewed for importance and usefulness. A different set of questions is used for different methodologies. Since this approach does not assign numerical scores, limitations were identified instead. Thus, all papers included in the review addressed a clearly focused issue, used an appropriate methodology and were judged relevant and with useful findings. Core to systematic review methodology is the non-selective way in which both positive and negative findings are reported (Petticrew and Roberts 2006).

Data were extracted into evidence tables detailing aims and location of studies, day centre type, publication type, theoretical frameworks used and sample, design, methods, findings and limitations identified (see Appendix 11).

Figure 7 summarises the searching and screening process.

Figure 7: PRISMA Flow diagram (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Moher et al. 2009)



3.8 Summary

This study used an embedded multiple-case study approach. Research was undertaken at four day centres, selected purposively against a typology of characteristics, and with four participant groups involved in these day centres. The overall sample of each individual participant group across four day centres comprised 23 attenders, 10 family carers of attenders, 23 day centre managers, staff and volunteers and 13 local authority professionals. Participants for each day centre numbered 16, 16, 18 and 19 and totalled 69. Family carers were challenging to identify and recruit, as were local authority signposters/referrers. Falling numbers and high proportions of cognitively impaired attenders reduced the sample from which to recruit. Centre staff and volunteer participation was high.

Mixed methods were employed; participant characteristics were measured quantitatively and their views gathered in qualitative interviews which were transcribed. Outcomes for attenders and carers were also measured quantitatively. Fieldwork was undertaken for fourteen weeks in centres consecutively. Individual participation was subject to meeting inclusion criteria and giving informed consent. Qualitative data were stored in secure databases. Thematic analysis of qualitative data was undertaken and data interrogated by participant characteristics. Use of validated scales is discussed in Chapter 7 and scale data presented in Chapters 7 and 8. Ethical and Research Governance approvals were granted prior to carrying out the research. A systematically conducted literature review was conducted to scope the research questions. Chapter 4 presents the findings of this review.

Chapter 4 The purpose, perceptions and benefits of day centres for older people without dementia: a review of the literature 2005-2017

This chapter examines the UK and non-UK evidence in English, from 2005-2017, about day centres for older people without dementia. It addresses research question one:

1. What is already known about the purpose of day centres, how they are perceived, who benefits from them and how?

Chapter 3 presented the methods employed to undertake this literature review. After providing an overview of the literature included in it, this chapter outlines the types of non-UK day centres appearing in the literature and their aims. This is followed by findings about how day centres are perceived. The outcomes of attendance and interventions in centres are then set out, separately, grouped under the four aims specified in the literature. Next, process outcomes are covered. Outcomes for health and social care and the systemic purpose of centres are then summarised. There follows an outline of what is known about day centre users. Finally, I sum up the findings of this review, discuss the limitations of the literature and the gaps identified which I aim to partially address with this study.

4.1 Overview of the literature

This section outlines the characteristics of the literature in this review, describes the different types of day centre appearing in the literature and defines the terms to be used here.

In total, 77 papers met the criteria for this review. Evidence tables, in Appendix 11, detail the location of studies, type of day centre referred to, publication type, theoretical frameworks used and sample, design, methods, findings and limitations. Three categories of literature were identified:

- Day centres or their attenders (46 papers)
- Not focused on day centres but addressed the review question (10 papers)
- Interventions carried out in day centres (21 papers).

Most literature had been published in peer-reviewed journals. Figure 8 and Figure 9 summarise their source countries and years of publication.

Figure 8: Countries of origin of papers

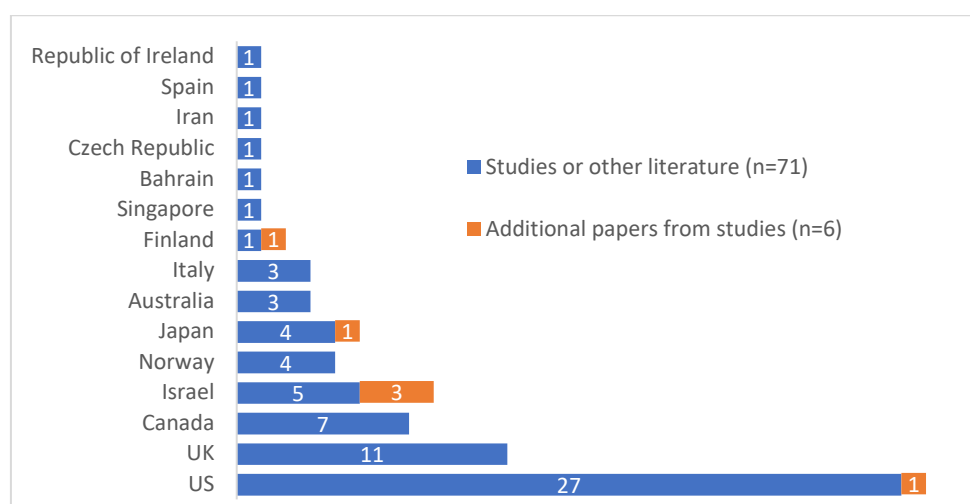
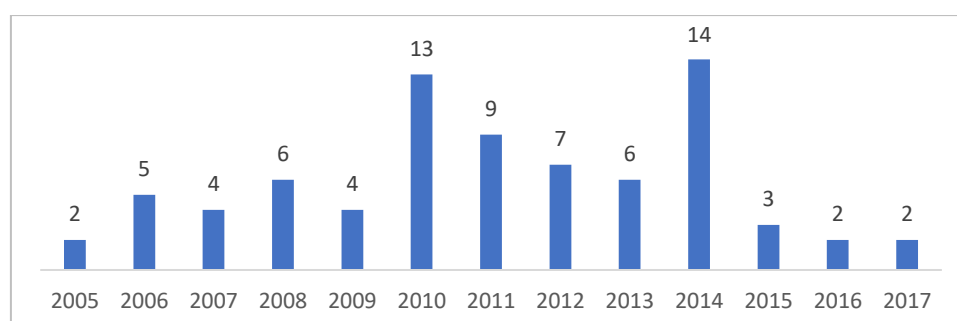


Figure 9: Years of publication



Excepting studies relating to interventions in day centres, just over half the literature was quantitative. A number used validated scales (n=16) which mostly measured depression, loneliness, physical function, health-related quality of life or social support. Many studies interviewed participants (n=22) or were based on surveys (n=9). Secondary analysis of data (n=7), observation (n=4), focus groups (n=6) and questionnaires (n=3) were less common methods. Eight papers were literature reviews (n=2), think pieces or expert opinion articles (n=4), evaluations (n=3) or case studies (n=2).

4.2 Terms used in this chapter

In Chapter 1, day centres were defined for this study as ‘community building-based services that provide care and/or health-related services and/or activities specifically for older people who are disabled and/or in need, which people can attend for a whole day or part of a day.’ In this chapter, ‘day centre’ and ‘attendance’ are used throughout regardless of centre type. ‘Attendance’ is used regardless of how older people ‘use’ day centres which many studies did not state. ‘Significant’ refers to findings that are statistically significant using criteria defined in papers. The term ‘outcome’ is used to refer to any impact, effect or consequence (Glendinning *et al.* 2008) whether beneficial or not. Research with older people and carers has defined three

types of outcomes of social care: change, maintenance/prevention and process (Qureshi *et al.* 1998). 'Process' outcomes pertain to the way services are accessed and delivered and may include feeling valued and respected, being treated as an individual, having a degree of control over the way a service is delivered, the extent to which a service fits with other support received and value for money.

4.3 Types of non-UK day centre in the literature, their aims and what they offer

A wide range of different types of day centre appears in the literature illustrating the breadth and complexity of day centres, both within and between countries. Descriptions of non-UK day centres, as given in the literature, are shown in Table 6. Most were said to provide socialisation and activities; some offered health services and rehabilitation. Target users included functionally impaired/frail, socially isolated or retired people and, less often, family carers. The Israeli model appears to be most similar to a typical English day centre.

The literature suggests that day centres may serve four purposes, all of which appear to fall within the English government's current policy of preventing deterioration and promoting wellbeing (HM Government 2014):

- | | |
|---|---|
| 1. To provide social and preventive services. | (Dabelko-Schoeny and King 2010, Fawcett 2014, Marhankova 2014, Liu <i>et al.</i> 2015, Fitzpatrick <i>et al.</i> 2005, Iecovich and Biderman 2013b, Kuzuya <i>et al.</i> 2012, Boen <i>et al.</i> 2010, Lund and Englesrud 2008, MaloneBeach and Langeland 2011, Shahbazi <i>et al.</i> 2016, Kelly 2017) |
| 2. To support continued independence of attenders. | (Dabelko-Schoeny and King 2010, Liu <i>et al.</i> 2015, Ron 2007, Kuzuya <i>et al.</i> 2012, Schmitt <i>et al.</i> 2010, Kelly <i>et al.</i> 2016) |
| 3. To support attenders' health and daily living needs. | (Dabelko-Schoeny and King 2010, Fawcett 2014, Liu <i>et al.</i> 2015, Al-Dosseri <i>et al.</i> 2014, Kuzuya <i>et al.</i> 2012, Boen <i>et al.</i> 2010, Lund and Englesrud 2008, Schmitt <i>et al.</i> 2010, Shahbazi <i>et al.</i> 2016) |
| 4. To enable family carers to have a break and/or continue with employment. | (Fawcett 2014, Al-Dosseri <i>et al.</i> 2014, Schmitt <i>et al.</i> 2010, Leyy <i>et al.</i> 2016)) |

The first three overlap: the concept of prevention is broad and is inextricably linked with independence and health, both mental and physical.

Table 6: Non-UK models of day centre appearing in the literature

Country	Name	Type
Australia	Day club	Newer model incorporates concepts of well-being and active ageing into traditional model that provides respite and supports older people with increasing impairments. Many renamed as Day Clubs to reflect new focus (Fawcett 2014).
Bahrain	Day care center	Provide health (including rehabilitation) & physical activities, meals, ' <i>a chance to socialize and have fun in a community based group</i> ' and aim to reduce burden on family carers (Al-Dosseri <i>et al.</i> 2014:2).
Canada	Senior centre	<i>'places for older adults to socialize or share specific interests with their peers... main goal is to meet the needs of retired people'</i> (Fitzpatrick <i>et al.</i> 2005:18).
	Adult day service	<i>'a setting where older people can engage in supervised, social, recreational, and therapeutic activities during the day'</i> (Kelly 2017:552) which offer ' <i>health monitoring, personal care, medication management, meals and social/recreational activities</i> ' (p554). They are ' <i>situated amid the continuum of home support services, which are designed to support older adults with functional and/or cognitive impairment so that they can continue to live at home</i> ' (Kelly <i>et al.</i> 2016:814). Kelly <i>et al.</i> 2016 describe these as a ' <i>social and emotional model</i> '.
Czech Republic	Senior centre	Place to engage in active ageing activities and meet people (Marhankova 2014).
Iran	Adult day care	<i>'... mostly established during the last decade....work under the direction and supervision of the State Welfare Organization (SWO) of Iran, and their costs are covered by the SWO. the SWO has prepared a service package for empowerment of older adults, including medico-rehabilitative and psycho-social services, based on bio-psychosocial model... All day care centres ... required to deliver their services according to this package'</i> (Shahbazi <i>et al.</i> 2016:719)
Israel	Day centre	Aim to enhance wellbeing of frail people lacking social contact and support (Iecovich and Biderman 2013b). Part of package of community services offered through Long-Term Care Insurance Law 1988 which encourages continued residence in community with increasing disability or dependence (Ron 2007).
Japan	Day care	A ' <i>program of nursing care, rehabilitation therapies, supervision and socialization that enables frail, older people, who are in poor health and have multiple comorbidities and varying physical and mental impairments, to remain active in the community.</i> ' Japanese long-term care system has a low eligibility threshold. (Kuzuza <i>et al.</i> 2012:323).
Norway	Senior centre	Support maintenance of physical and psychological activity, functional health, promote self-sufficiency and prevent loneliness and isolation (Boen <i>et al.</i> 2010, Lund and Englesrud 2008). Open to all aged ≥60 years (Ingvaldsen and Balandin 2011). Although these are characterised as welfare services, they do not provide statutory care and are paid for privately; often run by small staff body and volunteers (Boen <i>et al.</i> 2010).
Singapore	Day care center	Umbrella term encompassing 'senior care centers', 'day care centers (social)', 'senior activity centers', day rehabilitation centres, dementia day care, psychiatric day care, hospice day care and multidisciplinary medical day care. ' <i>A key enabler of aging-in-place is day care centers, which are non residential facilities that support the functional and social needs of seniors during the day</i> ' (Liu <i>et al.</i> 2015:e7).
US	Adult Day Service (ADS) centres	Umbrella term. ADSs provide support for people with functional limitations to remain in the community and reduce carer burden (Schmitt <i>et al.</i> 2010) using three models: - social (meals, recreational activities and some health services) - medical/health (social activities, health and therapeutic services) - specialised (care for specific groups e.g. dementia, learning disability) (National Adult Day Services Association (NADSA) 2015).
	Adult Day Health Centre	Medical model. ' <i>...offer a multidisciplinary team approach that includes skilled nursing and rehabilitation therapy in addition to the social model services. In some states, ADHC services are Medicaid reimbursable because they are considered to be an alternative to institutional-based long-term care</i> ' (Schmitt <i>et al.</i> 2010).
	Multipurpose Centre	Provide a range of social support services e.g. health, nutritional, educational and recreational activities, and promote opportunities for social interaction and involvement (Salari <i>et al.</i> 2006).
	Senior centre	Focus on socialisation and leisure; often volunteer run (MaloneBeach and Langeland 2011); often with a cross-generational reach; tend to be non-profit and publicly funded (Hostetler 2011).

A day centre's purpose is likely to influence what it offers, yet detailed descriptions of what they offer are generally absent from the literature and there is little about what attenders participate in. The most detailed was a weekly events schedule including '*exercise class, Bidwhist cards, talent group rehearsal, bone builders class, line dancing, Tai Chi, cribbage, knitting and crocheting, a Red Hat meeting, hula dancing, Spanish class, bingo, movies, a veteran's breakfast, poker, a dance social, and a panic/anxiety support group*' appearing in a US qualitative study (Hostetler 2011:173). Day centres in an Israeli quasi-experimental study (Iecovich and Biderman 2013b) were reported to offer meals, transport, social and recreational activities, health promotion (physical movement) and personal care. Pedicures, manicures, hairdressing, dentistry and laundry were also available, although it was not clear if these were in-house or visiting. Norwegian day centres were reported to offer balance, coordination and strength improvement exercise (Boen *et al.* 2010) and lectures, dance, handicrafts, music, meals, hairdressing and pedicures (Lund and Englesrud 2008). In Japan, they offered rehabilitative therapy, nursing, bathing, meals and socialisation (Kuzuya *et al.* 2006). A Canadian centre for people with sight loss offered group exercises, arts and crafts, discussion groups (e.g. on health, falls prevention, safety), informative talks (e.g. power of attorney, abuse), cognitive stimulation (e.g. games, language classes) and psychosocial groups (Wittich *et al.* 2014). Salari *et al.* (2006) outlined floor plans but not activities offered.

4.4 Perceptions of day centres

Conflicting perceptions of day centres were set out in an English social care sector magazine:

'For such an innocuous concept, day centres can be quite divisive. For some social care professionals and service users alike, day centres offer the ideal opportunity to provide targeted services to clients in a safe, stable environment. But others regard them as outdated and patronising, a service firmly stuck in the last century.'
(Sale 2005:30).

Despite such reported polarised views, little research was found about perceptions of day centres.

4.4.1 Professionals working in health and social care

That day centres are recognised to have a place in the continuum of care in some countries (e.g. Pardasani 2010, Kuzuya *et al.* 2012, Boen *et al.* 2010, Liu *et al.* 2015) contrasts sharply with the lack of English literature concerning perceptions of day centres.

Two qualitative English studies touched on perceptions. In Clough *et al.*'s (2007) study, nurses in frequent contact with less healthy older people were asked about their priorities for low-level support for older people. Day centres and services which reduce isolation figured among their priorities, but their main priorities were for support to carry out Instrumental Activities of Daily Living (IADLs are skills needed to live independently e.g. shopping, managing finances, preparing

meals) and Activities of Daily Living (ADLs are basic self-care tasks e.g. washing, dressing, toileting, eating), likely to be in-home. Brookes *et al.* (2013) reported that some local authority staff (care managers and brokers and commissioners) believed that demand for centres had reduced either because they did not offer a personalised service or because of individual preferences for alternative services.

Day centres did not appear at all in Miller *et al.*'s (2014) study of processes and commissioning influences in nine English local authorities. The top three preventive interventions for older people in which local authorities invested did not, apparently, include day centres but did include reablement, health promotion/prevention and information and advice. This may suggest an underlying perception that centres do not match local or national priorities. Decisions were reported to be based on readily available and trusted publications from a range of sources, excluding academic journals, previous experience and personal perspectives about what worked.

In the US, Kane *et al.* (2006) found advanced practice nurses (with post-graduate nursing education) and geriatricians to be the most positive professionals about day centres, with the former most likely to recommend these. Registered nurses, geriatricians, primary care practitioners, gerontologists, social workers and people working in health administration were negative about day care. The researchers concluded that recommendations appeared to be influenced by background, training and education.

4.4.2 Day centre managers

Two US studies explored centre managers' view of their work, their vision for their services' future (Hostetler 2011) and barriers to growth (Sanders *et al.* 2009). Managers and their senior staff participating in the former believed that centres suffered from an image problem. Manager participants in the latter highlighted the effect of terminology. They perceived that 'day care' was stigmatised, believing that some people preferred 'day services' as they imagined attenders of 'day care' to be disabled and older than themselves, and felt that centres were overlooked by professionals who lacked knowledge about their value.

4.4.3 Older people: attenders and non-attenders

Attenders

Three non-UK studies suggest that day centres are perceived as undesirable (Lund and Englesrud 2008) welfare services (Ingvaldsen and Balandin 2011), for people who are old, isolated, ill (Lund and Englesrud 2008) or miserable (Iecovich and Biderman 2013a), but that people's attitudes may become more positive after starting to attend one (Lund and Englesrud 2008). In a Norwegian study, attenders were observed creating distance from frailer and older attenders, who seemed to act as a reminder that they were also ageing (Lund and Englesrud 2008). This was done by

commenting to others on aspects of old age (e.g. a shuffling walk), explaining their own presence (e.g. for hairdressing) or justifying attendance as being helpful to others.

That negative attitudes may change was confirmed by a case study in Sale's (2005) article opening this section. A previously active 88-year-old woman, five years earlier, had reluctantly started to attend a day centre on the advice of her doctors. After three weekly visits, her negativity turned into enthusiasm, and she increased weekly attendance to two days. She believed that visiting her aunt's residential home had influenced her perception of day centres. In the same vein, a participant in Ipsos MORI's (2014) English research, who was receiving family support, said he would attend a centre if he were 'told to'.

Non-attenders

A small number of non-UK studies considering reasons for non-use and barriers to use of day centres may reflect participants' perceptions of these. Some non-attenders preferred to stay at home rather than attend a day centre (Iecovich and Biderman 2013a), were not interested in centres (Pardasani 2010) or expressed a lack of need for them (Iecovich and Biderman 2013a, Pardasani 2010). Since non-attenders in Iecovich and Biderman's (2013a) study were aware of what centres offered, this was thought to suggest a perception that these were a service for people from lower 'classes'. For some, the idea of seeing people with dementia or disability was difficult or upsetting. Iecovich and Biderman's (2013a) study confirmed the belief expressed by managers in Sanders *et al.*'s (2009) study that the stigma associated with day centres took the form of people not wishing to use centres whose attenders had disabilities or were older than themselves, more so in rural areas where others may become aware of a person's service use and dependency. There was also a perception that centre activities were uninteresting or unsuitable (Iecovich and Biderman 2013a, Pardasani 2010) or not culturally/language appropriate (Pardasani 2010, Ipsos MORI 2014), and that they lacked volunteering opportunities (Pardasani 2010). Non-attenders in Iecovich and Biderman's study (2013a) reported several reasons for non-attendance rather than one main one.

Baby boomer respondents (the two baby boomer waves include people born from 1946–1964) to a US survey (MaloneBeach and Langeland 2011) felt positive about day centres. They saw them mainly as a place of social engagement and for activities, but also as a carer support service. Many said they would be happy to use them in future but expressed a preference for multi-purpose, not segregated, centres. A literature review acknowledged the challenges Canadian centres may face in attracting baby boomers but concluded that they '*are already a traditional part of our culture and are widely recognized and respected*' (Fitzpatrick and McCabe 2008: 211).

4.5 Mapping outcomes of attendance and interventions against day centre aims

The next sub-sections present findings of the literature about outcomes of attendance and interventions in centres relevant to the four day centre purposes. The first covers prevention of decline, possibly averting the need for more expensive services. Literature related to the direct supporting of independence (including delaying a care home move) follows in the second. Literature linked with existing health conditions appears in the third, and the fourth covers carer support. In some cases, judgements were made about which section was most appropriate since meals, for example, may be categorised as preventive (e.g. of loneliness or malnutrition) or support with daily living. The section ends by covering process outcomes for attenders.

4.5.1 Providing social and preventive services

Attendance

Positive psychosocial outcomes of centre attendance were the most documented, mainly by non-UK literature and one important English study (Caiels *et al.* 2010).

Attending a day centre made a difference to the lives of most participants in qualitative US study (Dabelko-Schoeny and King 2010). Some said they enjoyed it, but it made no difference. Most impactful were social connections made with co-attenders, participating in or enjoying activities and being able to access services (e.g. occupational therapy), resulting in improved perceived psychosocial wellbeing. Having people to talk with helped some gain a better perspective of their own abilities (Dabelko-Schoeny and King 2010). Three-quarters of participants of a US quantitative study also perceived that attendance had improved their lives, largely attributing this to increased social support (Fulbright 2010). Since a high proportion reported starting to attend for social support and making new friends on whom they could rely at times of need, this suggests that outcomes met their needs. No mention of what reliance entailed was made or whether friendships extended beyond the centres, and most participants reported already having outside reliable friends. In an Australian mixed methods study (Fawcett 2014), attenders also reported benefiting from new social connections, feeling more stimulated, content and confident. Some reported increased social contact with family and existing networks outside the centres, suggesting that new friendships did not extend beyond centres but may have encouraged maintenance of existing relationships. Resilience scores improved with time. For attenders in a Norwegian qualitative study, social contact and feeling included were the main benefits (Ingvaldsen and Balandin 2011).

Reductions in depression and/or anxiety were reported in qualitative research (Dabelko-Schoeny and King 2010) and studies employing scales (Bilotta *et al.* 2010, Fawcett 2014, Santangelo *et al.*

2012). Fulbright (2010) found less reporting of depressive symptoms, using the Geriatric Depression Scale, significantly associated with having made 'close friends' (undefined). According to Wittich *et al.* (2014), insignificant changes in scores over 12 months in depression, friendship, the Timed Up and Go (TUG) test - which assesses mobility, hearing and visual function - suggested that attendance and rehabilitative activities at a centre for people with sight impairments had continued to prevent decline in general wellbeing.

Attendees in a large Israeli quasi-experimental study (Iecovich and Biderman 2013b) experienced significantly higher levels of emotional, physical and overall quality of life than non-attendees, measured by a validated scale. Higher wellbeing was significantly connected with social benefits, feeling that needs were met and attendance acting as respite for family carers. Variables explaining higher quality life were subjective (e.g. self-rated health) rather than objective (e.g. morbidity, number of visits). Frail older people participating in a very small qualitative study in the US perceived that intergenerational contact at a co-located day centre and pre-school child care centre impacted positively on their emotional wellbeing (Weintraub and Killian 2007), physical wellbeing and activity (Weintraub and Killian 2009). Interestingly, engagement with the children was described as volunteering.

Developing a strong social support network was more important for the emotional wellbeing of women living alone, compared with married women, as measured by a life satisfaction scale in a US case-control study (Aday *et al.* 2006). The former experienced significantly greater improvements in life satisfaction, particularly in some areas (less lonely, laugh more, worry less about future, have more energy and cope with stress better) and were more likely to socialise outside centres with new friends made at them. Participants with supportive networks were more likely to join in centres' activities. Responding to open questions, some reported gaining a sense of belonging and, for some, friends acted as 'substitute family members' (Aday *et al.* 2006: 68). For attendees who were actively engaged with children at an intergenerational centre, children acted as substitute family, particularly for those with distant or no family (Weintraub and Killian 2007). Children were encouraged to address attendees as grandma/pa which, perhaps, fostered family type bonds. Half of the attendees did not feel the need to actively engage with the children as they felt their emotional needs as met by peers and staff. Two qualitative studies reported how day centres felt like a second home for some (Ingvaldsen and Balandin 2011, Lund and Englesrud 2008).

Social participation appears to be of high importance. A large, English study (Caiels *et al.* 2010) that developed a tool (Adult Social Care Outcomes Toolkit) for measuring the impact of specific services on quality of life (including the inherently difficult-to-measure intangible aspects of

impact) found that day centre attendance increased overall quality of life. The greatest impact concerned a good social life (for 61% of attender respondents). Reflecting the multi-dimensional nature of quality of life, outcome domains were social participation; meaningful occupation; meals and nutrition; feelings of safety; control over daily life; home cleanliness and comfort; personal cleanliness; dignity and respect; and anxiety (later eliminated).

Although such tools aim to isolate impact, improvements to wellbeing cannot necessarily be attributed to day centre attendance alone. Santangelo *et al.* (2012) noted that 'positive events' in people's lives may also explain these at the micro level.

Three comparative studies led to interesting conclusions. Using a loneliness scale, Iecovich and Biderman (2012) found no difference between frail attenders and non-attenders, and speculated that attendance might impact positively on loneliness considering the groups' differing predisposing factors, enabling factors and need. People may have attended centres to alleviate loneliness, hence may have benefited from this since moderate to severe loneliness in the two groups was similar. Ron (2007) found significantly higher self-esteem and sense of control over life and circumstances in centre attending women than women receiving home-based care and support. Since service type explained almost half the variance in self-esteem, she argued that the structure provided by day centres, the sense of purpose gained from creativity, a sense of belonging, involvement and social ties with other members and staff may have contributed to higher self-esteem. Finding that mortality was lower in attenders than non-attenders, Kuzuza (2006) argued that attenders may have benefited from informal monitoring of mental and physical health by staff. One may speculate that centre attenders are likely to feel more comfortable speaking with staff and volunteers about their health, having built more of a rapport with them than with GPs whom they may see infrequently.

That activities and support took place in a group setting has been argued, or reported, to contribute to positive outcomes (Ron 2007, Fitzpatrick 2010, Dabelko-Schoeny and King 2010) including self-esteem (Ron 2007) and feelings of involvement and belonging to a group (Fawcett 2014, Iecovich and Biderman 2013a, Ingvaldsen and Balandin 2011, Lund and Englesrud 2008, Ron 2007). Some of the intangible and difficult to measure contributors to improved quality of life that relate to congregate settings surfaced in Ipsos MORI's (2014) small English study. These included having a range of people to talk to, feeling energised by being around people, helping clear up after meals and enjoying recounting the day's activities to family.

Two studies reported outcomes for volunteers, an undefined term, and evidenced how people may interchange between attender and volunteer in certain settings. Using participant

observation and informal conversations, a Norwegian study (Lund and Englesrud 2008) reported that volunteering at a centre helped people to feel useful. Around 70 per cent of attenders also volunteered at their centre. Using validated scales, a Canadian study (Fitzpatrick *et al.* 2005) found that attenders who also volunteered perceived better physical health, social support and support from advice given at a personal level than non-volunteering attenders. Although unspecified, a possibility is that the participants who volunteered (55%) may have done so at the co-located Adult Day Health Centre. Such outcomes may be said to fall within the first purpose of day centres, although they are unique to attenders who also volunteer, an unlikely situation in the English system given the general poor health of local authority-funded attenders.

Two studies concerned functional-related outcomes of attendance of integrated health and social care day centre rehabilitative models. Attending one Iranian centre, which delivered a bio-psychosocial model of service provision, resulted in decreased attendee disability and improved functioning compared with a control group whose disability increased over six months (Shahbazi *et al.* 2016). Attendees experienced significant positive change in disability in six domains: getting around, getting along with people, life activities, participation, self-care, and understanding and communication. Between-group differences were significant in all but the 'self-care' and 'understanding and communication' domains. In Wales, referrals to centres (by health or social care), for individually-tailored therapeutic packages aiming to extend independence, were for a maximum of 18 months (Murphy *et al.* 2017). At least once weekly attendance, of seven hours, resulted in a small, but insignificant, improvement in physical wellbeing, but no significant change in psychological wellbeing or functional mobility.

Interventions

Seven interventions evidence centres' potential to contribute to preventing a decline in mental, physical and cognitive health and one to improved social engagement. Although not explicitly aiming to, two also led to increased social networks. An evaluation resulted in improved links with another service (Wittich *et al.* 2014). Finally, using data from a demonstrator project, one paper argued that centres have a role to play in the prevention arena (Cabin and Fahs 2011).

Two humour-based group programmes, employing validated scales to measure change, resulted in reduced anxiety and depression and improved psychological wellbeing at clinically significant levels (Ganz and Jacobs 2014) and significantly improved life satisfaction (Mathieu 2008). However, Ganz and Jacobs' (2014), which encouraged the use of humour strategies, did not impact on general health, health-related quality of life or psychological distress. Mathieu's (2008) informational and interactive sessions dealt with factors contributing to happiness and life

satisfaction. Participants were encouraged to share personal stories and, bonding through humour, began to socialise together outside sessions.

Small, but insignificant, improvements in levels of depression (higher when this was mild) resulted from a year-long weekly group programme of transport to a centre, exercise and self-help (Boen *et al.* 2012). The programme, which aimed to reduce depression by addressing social isolation, was more successful at addressing this for women. New friendships and home visits by these friends were reported by 40 per cent of the female participants, whereas men did not report new friendships.

A five-week volunteering intervention aiming to increase well-being led to insignificant improvements to purpose, self-esteem and self-perceived health. However, after completion, intervention group participants' self-esteem and self-perceived health decreased significantly but remained above baseline levels (Dabelko-Schoeny *et al.* 2010). Both participating centres later formed similar groups to promote civic engagement. Dabelko-Schoeny *et al.* reasoned that such interventions '*could be integrated into care plans and become a treatment option for increasing participant well-being*' (Dabelko-Schoeny *et al.* 2010:700).

Two interventions tackled cognitive fitness. First, Fitzpatrick (2010) found brain fitness activities (laughing with others and working together on a project) significantly positively related to mental health (spirit, happiness and an interesting life), and aerobics, strength exercises, group work, listening to speakers, learning computers and new languages to self-reported physical health, as measured by the Psychological General Well-Being Schedule. Strength training was important for both mental and physical health. Second, weekly psychosocial group attendance over three months significantly improved cognition among lonely older people (Pitkala *et al.* 2011) as well as lowering mortality and use of health services over a two-year follow-up period (Pitkala *et al.* 2009). After one year, cognition remained significantly improved.

Participants and the service provider benefited from the seventh, a weekly facilitated two-hour discussion group of attenders and people of different age groups from the wider community (Gallagher 2016). This was viewed as an enhancement to the usual care- and health-focused programme by participants and the provider. Participants reported getting to know co-attenders better through reportedly intellectually stimulating conversations based around questions such as 'is happiness a choice?' This was beneficial as most were also neighbours. In addition to being fun, the purposeful and meaningful topics covered and the personal nature of some conversation material improved mutual understanding and tolerance. Staff and attenders got to know each other better which improved relationships and gave staff insights into participants' views on the centre and ideas for new activities. It was also said to enable links with the community by giving

an information-sharing opportunity, for example about local events, issues or security matters conveyed by local police.

Two papers addressed connections with other services. Links with a co-located support programme for people who were deaf or hard of hearing were enhanced after a centre for people with sight loss was evaluated and subsequently introduced hearing screening (Wittich *et al.* 2014). Based on the findings of a US 'healthy aging' demonstrator project, Cabin and Fahs (2011) argued that day centres were well-placed to contribute to the prevention 'agenda' by identifying hearing and vision impairments, screening for depression, and perhaps offering falls prevention programmes and depression treatment in collaboration with primary care or community health centres. They identified factors that significantly predicted depression (visual and hearing impairment, lower income, being disabled, low physical activity, having arthritis/rheumatoid arthritis, frequent falls), some of which may be present in attenders.

4.5.2 Supporting independence

Attendance

Analysis of data about new recipients of one Canadian provider's home and day centre services showed a positive relationship between consistency of attendance and continuing to live in the community when comparing time to institutionalisation between functionally and/or cognitively impaired non-attenders and attenders over a four-year period (Kelly *et al.* 2016). Institutionalisation risk decreased significantly with 'High' and 'Moderate' attendance. Categories reflected frequency and length of attendance. In the 'High' group, increasing numbers of months receiving the range of services also increased institutionalisation risk which was significantly mitigated by attendance. Length of time at home converged between the 'None' group and the Low and 'Moderate' groups at one and three years respectively.

A longitudinal analysis of residence locus (community, care home) and service use in the US found that, used in combination, day centres and personal care may enable people with functional limitations to remain in the community or to live in the community following a period in a care home (Chen and Berkowitz 2012). From their evaluation of a centre for people with sight loss, Wittich *et al.* (2014) concluded that participation in rehabilitative services offered may support independent living as all but one in the study remained in the community in the subsequent year. Aday *et al.* (2006) found that women living alone who had developed supportive networks at day centres were more likely than married women to join in with health promotion activities and significantly more likely to feel that these supported their continued independence. Fawcett (2014) concluded that attendance appeared to play a role in reducing hospital admissions and delaying care home moves where these were due to socio-health related reasons, but methods

were not fully reported so it is unclear how this conclusion was reached. Many attenders in Ingvaldsen and Balandin's (2011) study agreed that attendance had contributed to their remaining at home.

More broadly, some day centres also appear to offer potential practical support. Attenders in Aday's study (2006) perceived that practical support (e.g. transport, shopping) would be available from new and 'close friendships' (undefined) developed at centres at times of need. When testing the ASCOT, the second highest domain of benefit was home cleanliness and comfort which '*may be due to reducing the tasks associated with food preparation and personal cleanliness that would otherwise take place at home*' (Caiels *et al.* 2010: 37).

Interventions

The literature suggests that day centres may play a role in supporting people to age in place and that people may first access them when their functional capacity and support network have reduced. Exercise and falls prevention interventions in centres may maintain or improve physical function and quality of life, impacting on attenders' potential ability to remain independent. Four papers reported such programmes.

One study concluded that, rather than supplementing informal support, day centres replace insufficient informal networks and home environments that are no longer suitable due to reduced functional capacity (Del Aguila *et al.* 2006). By assessing new applicants and matched non-users of formal services, Del Aguila *et al.* introduced the idea that physical function and informal networks were inter-related and could affect service use/non-use.

The first of the four exercise and falls prevention interventions was an evidence-based, moderate-intensity weight-bearing exercise programme which, after 16 sessions, significantly improved lower body strength, agility and balance in older people needing help with ≥ 1 ADLs (Henwood *et al.* 2013). Improvements in walking speed and right-hand grip became significant after 16-24 sessions and 24 sessions respectively. The second was a short-term, regular exercise programme that improved spinal ranges of motion (Battaglia *et al.* 2014). However, it was aimed at active older people with no recent history of falls who may not be representative of centre attenders in England. The third involved the use of poles in walking undertaken at centres as part of a usual day (Ota *et al.* 2014). Despite that pole-walking time was short, significant improvements were experienced in health-related quality of life associated with activity and function and to some aspects of posture. There were no changes to physical function or fitness, but pole walking appeared to maintain physical function as measured by the Timed Up And Go (TUG) test which assesses mobility. Ota *et al.* concluded that pole walking could be realistically undertaken at centres since it did not involve physiotherapists or occupational therapists who are not usually

employed by them. However, the sample size was small, environmental conditions differed for intervention and control groups and pole walking time very low although this did mirror actual circumstances. The fourth found that continuous participation, for three years, in education-focused falls prevention service improved mobility in older community-dwelling people when compared with individuals who dropped out after a year (Yamada and Demura 2014). However, details of the service and participants were scant, and no reference was made to the qualifications of the course leader. It may be argued that this length of participation in any programme may be an unrealistic expectation given attenders' poor health.

Finally, Vogel *et al.* (2007) evaluated a joint programme with public health which addressed targets for both the housing provider and the public health department. This pilot collaborative health outreach programme in a US public housing development started when the housing provider realised it could not offer health services required by the increasing numbers of people ageing in place. Day centre managers selected activities from set options (e.g. exercise, healthy cooking demonstrations, vaccinations, mental wellbeing activities, support groups and health education) to supplement their own provision.

4.5.3 Supporting attenders' health outcomes and daily living needs

Attendance

Six quantitative studies addressed outcomes of attendance concerning physical health.

One study found that almost half the women who had been attending for at least a year had increased their exercise participation and one-third had developed healthier eating habits (Aday *et al.* 2006). Another found no significant differences in health-related quality of life (physical function, social function, mental health) between attenders and non-attenders after 12 months either in-group or between groups, but attenders' daily lives were significantly less restricted by their physical or emotional health (Schmitt *et al.* 2010). Another found no significant difference between attenders' and non-attenders' use of hospital or specialist health services which was related to morbidity rather than day centre attendance (Iecovich and Biderman 2013c). This study concluded that the 'social model' does not meet people's health needs and health services might be offered in day centres. A Japanese study found functional status of new attenders with low needs more likely to decline significantly over 18 months than that of new home help users, but concluded this was due to older age rather than service effectiveness (Ishibashi and Ikegami 2010). In Canada, Fitzpatrick *et al.* (2005) were surprised to find that social support from friendship was not one of the factors that significantly affected health. The final one found attendance associated with reduced mortality at 21 months in a similar population (Kuzuya *et al.* 2006). However, this latter finding is marginal to this review since dementia was present in 42 per

cent of attenders and 30 per cent of non-attenders, and the characteristics of survivors and the dead were not given.

Also, from her mixed methods study, Fawcett reported physical health improvements in attenders, but without details (Fawcett 2014), and participants in a qualitative study felt that attendance was important for the improvement and maintenance of health (Ingvaldsen and Balandin 2011).

Interventions

Daily, short- and long-term interventions and outreach taking place in centres to support health and daily living needs have encompassed nutrition, management of existing conditions and health promotion and improvement. Formal relationships with health services were the subject of two papers.

To support nutrition at the most basic level, the literature commonly reports centres providing lunch. Several studies, referred to in section 4.7.2, convey the value placed on group eating particularly by people living alone. One very small qualitative study (McHugh *et al.* 2015) contextualises this. Few of the older participants prepared meals at home; instead they ate at family members' homes or day centres or had home-delivered meals. For some, sensory impairment or lack of teeth affected their eating. Unaddressed dental problems were linked with poor appetites by health professionals who thought that older people may lack skills, appetite or motivation to cook, particularly if without company or after bereavement, and noted how adapted cutlery and crockery could support independence. McHugh *et al.* noted that services offering nutritional and social support can be delivered concurrently.

Interventions supporting the management of existing conditions were blood pressure monitoring, self-care education, reduction of urinary incontinence and medication review.

The potential for blood pressure monitoring to be undertaken at centres is suggested by one low-cost programme and one using expensive equipment. The first resulted in clinically significant reductions in blood pressure in more than half (62%) of people having their pressure measured more than once during a six-month monitoring programme in six-day centres (Truncali *et al.* 2010). However, just over half the participants used the programme only once. Equipment and volunteer lay health educator training were provided by the local Public Health Department which also made quality assurance visits. The second located telehealth kiosks with blood pressure monitoring equipment for 10 months in four centres (Resnick *et al.* 2012). Blood pressure declined among study participants despite them not always complying with instructions and whether or not their blood pressure data were monitored remotely by nurses (via a central IT

system and email alerts). Such initiative may enable monitoring to be built into normal routines, thus bridging the gap between check-ups, and may reduce the risk of cardiovascular disease, leading to cost savings. However, equipment may have to be provided by health budgets as centre staff reported prohibitive purchase and maintenance costs.

Improved ability to self-care resulted from two programmes. A four-week lay educator skill-building programme for people diagnosed with heart failure significantly improved knowledge of heart failure, management and maintenance, as measured by validated instruments, in an intervention group compared with a control group (Dickson *et al.* 2014). No changes to health-related quality of life were experienced. Cost-effectiveness analysis was not built into the study. A three-month programme of informative and motivational video screenings followed by moderated discussion about chronic conditions significantly improved self-rated ability to take preventive actions, manage symptoms, find and use appropriate medical care and make decisions about care with health professionals (Frosch *et al.* 2010). Participants also undertook more walking and vigorous activity, and their physical and mental health-related quality of life improved. That no participant viewed a video individually despite being encouraged to do so may suggest that facilitated groups improve participation.

Two interventions reduced urinary incontinence (UI). Two months of supported pelvic floor muscle training (Kegel exercises) significantly reduced UI in older women attending one centre (Santacreu and Fernandez-Ballesteros 2011). Exercises had been explained to all participants by GPs, but they had not performed them prior to the centre information session which confirms importance of availability of expert supervision for the acquisition of new habits. Incidence of UI decreased in sedentary attenders who improved their physical performance (balance, gait, strength and endurance) following a behavioural intervention to increase walking (Morrisroe *et al.* 2014). This longitudinal study showed associations between better mental and physical health-related quality of life and lower risk of UI, and between depression and higher UI. The fact that data were missing and urge and stress UI were not separated may have affected the results.

Comprehensive medication reviews carried out at 13 US centres by supervised pharmacy students led to resolution of a large number of medication-related problems and better medication use (McGivney *et al.* 2011). Supervisors observed that students also improved their communication skills and clinical decision-making, better understood their role as medication managers, and realised that people may be less independent than apparent. In a specialist journal for pharmacists about the evolving roles of day centres, Wick (2012) agreed that trainee health professionals can benefit from exposure to older people at centres. She reported that some pharmacists have been carrying out activities in day centres to support attenders' health and

mobility for some time (e.g. medication reviews, targeted falls prevention, education), but these experiences were based on expert knowledge and were unreferenced.

With respect to health promotion and improvement, two interventions covered above led to improved physical activity and performance (Frosch *et al.* 2010, Morrisroe *et al.* 2014). Two further interventions encouraged weight loss and activity. A lifestyle behaviour modification programme, that had been adapted to be delivered by trained lay people, led to clinically significant weight loss in an obese intervention group compared with an obese control group (West *et al.* 2011). Shorter than the original programme by four weeks, it was more sustainable despite resulting in lower weight loss. A professionally-led four-month programme for attenders with multiple chronic conditions encompassing low-impact exercise, nutrition education and weight management led to improved physical and mental health (Kogan *et al.* 2013). It resulted in significant improvements to fitness, daily walking distance and hours of weekly exercise, and significant reductions in depression and body measurements. Kogan *et al.* speculated that peer support may have contributed to programme adherence.

Formal relationships with health were the topic of an English study and a policy analysis of day centre development in the US. Tucker *et al.*'s (2014) survey of English Community Mental Health Teams found centres to be the second most common venue for formal outreach after care homes, but their characteristics were unspecified, and they may have been specialist dementia day centres. Some day centres in the US were reported to have developed strategic partnerships, for example with home health services, to remain solvent (Dabelko *et al.* 2008). Cross-referral between partners increased the number of clients as well as reducing public costs since centre attendance was less costly than in-home services.

4.5.4 Supporting family carers

Attendance

Only two studies related to centres' fourth purpose. Using validated scales to determine levels of burden and quality of life, an Israeli study found similar overall quality of life and burden among family carers of people receiving live-in or live-out home care or attending day centres (Iecovich 2008). However, carers of attenders experienced a better psychological quality of life, with centre use significant in explaining this. In a Canadian study that compared users of home care (i.e. personal care) with people using these and day centres, a slightly lower percentage of attenders' carers reported burden, regardless of frequency and length of attendance, compared with those using home care only (Kelly *et al.* 2016).

Attendees in a US qualitative study perceived that centre attendance decreased their carers' burden, as carers did not have to worry, which they thought improved their relationship (Dabelko-Schoeny and King 2010).

Interventions

Although English policy encourages the support of carers (HM Government 2014), direct evidence of this was not found although some interventions outlined above have potential to reduce carer burden. For example, Henwood's (2013) study of an exercise programme, in a day centre offering respite for carers, showed potential to prolong independence.

4.5.5 Process outcomes for day centre attendees

Studies identified relating to process outcomes covered relationships with staff and the importance of these being respectful and empowering.

From their English research into outcomes-focused social care services, Glendinning *et al.* concluded that '*day centres could provide excellent quality services, with a high emphasis on process outcomes*' (Glendinning *et al.* 2008:61). Attendees in this study reported valuing being linked with a staff member with interests similar to their own. They also appreciated the respect they were shown and the personalised and flexible nature of day centres. A small, English ethnographic study about frailty provides an illustrative example (Ipsos MORI 2014). A centre worker was observed helping an attendee work out what she owed for her tea which took her away from other tasks, suggesting respect for the attendee's wish to retain as much control as possible within their life. Over 90 per cent of attendees in Caiels *et al.*'s (2010) English study were quite or very satisfied with support received from centres' care workers, usually or always happy with the way they were treated, thought workers usually or always did a good job, nearly always or always did the things they wanted done and said their relationship with care workers was good or excellent. Finding that attendees in her Israeli study were significantly more satisfied with 'expressive' aspects of care provided than home care recipients, Ron (2007) suggested that this indicated better emotional support from centre staff who maintained contact with attendees who were unable to attend. Attendees in this study also felt more in control of their lives than home care recipients.

Three non-UK studies reported the importance of empowerment. The second most impactful experience for attendees in Dabelko-Schoeny and King's (2010) study were relationships with staff that empowered them by, for example, acknowledging their feelings, giving choices and helping them to learn new skills. Attendees in an Australian study felt enabled '*to exercise self-direction*' (Fawcett 2014:843). Having choice about levels of contact with children was important for attendees of an intergenerational centre and helped them to feel respected (Weintraub and Killian 2007).

4.6 Outcomes for the health and social care system and the systemic purpose of day centres

Earlier sections of this chapter have covered purposes of day centres with respect to individuals. The literature also reported outcomes for health and social care systems and joint working in the provision of interventions at centres.

Funded by the government's Invest to Save budget, Caiels *et al.*'s (2010) large English study was unique as the instrument developed is a cost-utility tool that enables financial quantification of social care service outcomes. The study found centres to be cost-effective if guidance used by NICE to judge cost-effectiveness of health services relative to outcomes was applied. The researchers concluded that there was '*a 92% probability that day care is cost-effective at a £30,000 per ASCOT threshold*' (Caiels *et al.* 2010:66) in that attendance improved outcomes '*at a cost equivalent to just under £25,000 per 0.1 unit improvement, on the 0-1 scale, in ASCOT per service user on average*' (Caiels *et al.* 2010:74). Notably, though, there was '*a diminishing effect size with greater need, meaning that a needs based rule which only prioritised high needs potential recipients would generally not produce the greatest wellbeing improvement in the population for a given budget*' (Caiels *et al.* 2010: 67).

We have seen that a number of preventive and health-related interventions were implemented in centres with positive outcomes. Some were motivated by potential cost savings elsewhere (e.g. falls prevention, management of existing health conditions) but did not state potential savings or where these might be expected.

Only three non-UK studies explored use of other health services, one of which calculated cost savings. A Finnish randomised control trial (Pitkala *et al.* 2009) found lower use of health services by lonely attenders over a two-year follow-up period after three months of weekly psychosocial group work at day centres. Estimated annual savings were €943 per person. The intervention involved health or social care professionals currently unlikely to be employed at English day centres (nurses, occupational and physiotherapists). An Israeli quasi-experimental study (Iecovich and Biderman 2013c), found no reduction in use of hospital and specialist care resulting from centre attendance, but did not consider the use of primary care which may have been more appropriate for a social model with psychosocial benefits because underlying comorbidities imply a need for specialist care. Analysis of data concerning matched pairs of attenders and non-attenders of a Canadian providers' centres over a 100-day period concluded that attenders spent significantly fewer days in hospital than non-attenders and their hospital stays were significantly shorter (Kelly 2017). Rates, but not numbers, of Accident and Emergency attendance and hospital admission were also significantly lower. Kelly (2017) speculated that regular contact with health

care professionals (average 1.7 weekly days and 8.6 months of attendance) may have meant *'problematic issues for an attendee would be identified earlier (...) be directed to an emergency room or hospital before their issue became severely acute'* [pp558], and noted the need for further research. Despite the possibility that higher presence of spousal carers among attenders (48%) than non-attenders (27.8%) may have contributed to health problems being acted upon early, this was not discussed.

The literature has provided examples of cooperation with health and public health, with potential benefits to the health system as well as individuals. For example, attention has been drawn to the potential for trained lay people to successfully deliver interventions (e.g. Dickson *et al.* 2014, West *et al.* 2011) and, as noted above, how automatic and remote monitoring of blood pressure data in telehealth kiosks at day centres may have contributed to better use of nurses' time (Resnick *et al.* 2012).

Several interventions involved professionals not normally employed by English day centres. For example, training staff to deliver exercise (e.g. Henwood *et al.* 2013) would incur cost. Pitkala's (2011) groups were led by registered nurses, physiotherapists or occupational therapists.

Although such activity might be unusual for England, since they would involve weekly visits from expensive professionals, potential for implementation might be explored given the promise of benefits for participants and potentially lower subsequent health costs.

An initial challenge in working jointly with health was reported to be differing organisational cultures, although Vogel *et al.* (2007) indicated that working became more 'joined-up' over the four-year project. Interpretations of the term 'outcomes' varied between professionals from different backgrounds (Glendinning *et al.* 2008) and there is a risk that change outcomes may dominate the development of services to the detriment of longer term maintenance outcomes (Glendinning *et al.* 2008).

4.7 Day centre attenders

To understand who benefits from day centres and how, it must be established who uses them. With no central register, this is problematic in England. The only data concern people aged over 65 in receipt of local authority provided or commissioned day centre places. Chapter 1 outlined how half of such attenders are physically frail or disabled, one fifth have dementia and 4 per cent have hearing, vision or dual sensory loss (NHS Digital 2014).

4.7.1 Characteristics of attenders

Twenty-seven papers reported some characteristics of attendee participants. Age, gender, marital status and living arrangements were most commonly reported. Sixteen studies reported physical and/or mental health. Fourteen studies provided data about education and eleven about income. Only one study (Caiels *et al.* 2010) was conducted in England. In their review of UK literature from 2000-2013 about equalities, Manthorpe and Moriarty (2014) noted a dearth of contextual information about attenders, including their equality characteristics (age, marriage/civil partnership, disability, race, religion or belief, sex, sexual orientation or gender reassignment). This review found no studies reporting attenders' religious affiliation, sexual orientation or gender reassignment.

A tendency for attenders to be female, older, living alone, widowed/divorced/single, with no more than secondary education, low income and with multiple health conditions and medications was indicated by 24 studies (Aday *et al.* 2006, Al-Dosseri *et al.* 2014, Bilotta *et al.* 2010, Cabin and Fahs 2011, Caiels *et al.* 2010, Dabelko-Schoeny and King 2010, Fitzpatrick *et al.* 2005, Iecovich and Biderman 2013a, 2013b, 2013c, 2012, Ingvaldsen and Balandin 2011, Kuzuza *et al.* 2006, Lund and Englesrud 2008, Morrisroe *et al.* 2014, Pardasani 2010, Pitkala *et al.* 2011, Santangelo *et al.* 2012, Savard *et al.* 2009, Schmitt *et al.* 2010, Wittich *et al.* 2014, Iecovich and Carmel 2011, Ganz and Jacobs 2014, Kogan *et al.* 2013, Fulbright 2010, Frosch *et al.* 2010, Dickson *et al.* 2014), although some of these only reflected a few of these tendencies. Three studies compared the characteristics of attenders and non-attenders. Two broadly concurred with this (Boen *et al.* 2010, Iecovich and Biderman 2013a, 2013b, 2012) and one only on living arrangements and education (Iecovich and Carmel 2011).

Since these data are derived from research participants rather than national surveys, they may be unrepresentative due to studies' differing study foci, inclusion criteria, types of centre and systems. Nevertheless, it is unsurprising given longer life expectancy of women, higher prevalence of comorbidities with older age and as low numbers of people of older ages progressed beyond secondary school.

Apart from for living arrangements, the literature recounts few details of attenders' lives outside day centres. Of attenders in Caiels *et al.*'s (2010) English study, 13 per cent reported regularly volunteering, mainly between 1-8 hours every week, but no further data about this activity was provided. A Norwegian ethnographic study mentioned that one person also attended a literature course at another centre (Lund and Englesrud 2008).

Evidence about outside social support is conflicting, although study participants varied greatly. A quantitative Australian study concluded that having an inadequate informal network and an

unsuitable home environment contributed to the decision to apply to attend a day centre (Del Aguila *et al.* 2006). A quarter of attenders in an evaluation of a Canadian centre for people with sight loss were socially isolated or with low social support (Wittich *et al.* 2014). In contrast, independent, healthy attenders in a US study had a great diversity of social networks (Chaichanawirote and Higgins 2013). An Israeli comparison of attenders and non-attenders found the former to be significantly more likely to have larger family networks than non-attenders, but less contact with them (Iecovich and Carmel 2011). In a US study, most attenders, over half of whom were aged 75 or older, reported having friends who could be relied on outside their centres, as well as friends made at centres (Fulbright 2010). A large Norwegian quantitative survey measured social support but did not report this separately (Boen *et al.* 2010).

As for other formal services, a US case-control study found attenders received, on average, more monthly hours of home care (38.8) than non-attenders (26.6) (Schmitt *et al.* 2010). Other services received by people attending day centres as part of a Japanese long-term care package, were home help, used by 32 per cent, and home-visiting nurses, used by 40 per cent (Kuzuya *et al.* 2006), but almost half the sample had dementia. In Canada, receiving ADL assistance on attendance was found to be significantly associated with more regular attendance as a proportion of scheduled days (Savard *et al.* 2009).

Finally, rising numbers of new ageing populations may increasingly diversify the attender profile. People with learning disabilities are living longer, usually considered to have reached old age around the age of 50 due to a tendency to develop health problems at younger ages (Emerson and Hatton 2011). In a small UK study, participants aged 41-64 with mild to moderate learning disabilities reported highly valuing their day centres, considering these to be the social hub of their communities and somewhere to be occupied, active, eat lunch and meet friends (Judge *et al.* 2010). They were concerned about becoming isolated and lacking purpose once they stopped attending when they reached 65, which was an expectation, suggesting demand for places.

4.7.2 Why people attend day centres and what they value about this

The literature suggests that the reasons people say they attend day centres and what they value about them are linked with mainly the first, but also centres' fourth, purpose (providing social and preventive services and carer support). Although not explicitly stated, these suggest that attenders' perceptions of day centres were fairly positive, albeit once attending. Findings also indicate that people may have been socially isolated and experiencing poor wellbeing when they started attending a centre. Again, it is important to keep in mind the different operating models and target users.

In non-UK, mainly qualitative, studies, people have reported reasons for attending day centres. These include improving their life in general, their wellbeing and mood (Iecovich and Biderman 2013a), improving or maintaining health (Iecovich and Biderman 2013a, Ingvaldsen and Balandin 2011), wanting to socialise, make friends (Iecovich and Biderman 2013a, Pardasani 2010, Marhankova 2014, Fulbright 2010) and feel less lonely (Iecovich and Biderman 2013a). Some were attracted by the activities (Ingvaldsen and Balandin 2011, Lund and Englesrud 2008, Fulbright 2010), the chance to eat meals in company (Pardasani 2010, Ingvaldsen and Balandin 2011, McHugh *et al.* 2015) and others simply felt they met their needs (Iecovich and Biderman 2013a). Some women said they offered the opportunity to focus on themselves in retirement after years focusing on others' needs (Marhankova 2014). Some felt attendance would offer respite to family carers (Iecovich and Biderman 2013a). Attenders reported valuing that day centres were more than just a meeting place: they were a place to feel included (Ingvaldsen and Balandin 2011) or that provided much-needed rhythm in their lives after retirement or spousal bereavement (Lund and Englesrud 2008). Some valued being able to eat with others (McHugh *et al.* 2015).

4.7.3 Who benefits most?

A small number of studies concluded that some attenders benefited more than others. Their characteristics included:

- living alone (Caiels *et al.* 2010, Fawcett 2014)
- being mobility impaired (Fawcett 2014) or with higher ADL needs (but not very high ADL needs i.e. 5 ADLs) - the higher needs, the greater the outcomes improvement, except at the highest need levels (Caiels *et al.* 2010).
- attending more frequently (Kuzuya *et al.* 2006, Bilotta *et al.* 2010, Caiels *et al.* 2010) or for longer hours or periods (Dabelko-Schoeny and King 2010, Fawcett 2014) compared with less often or for a shorter time³
- starting a new activity (Fitzpatrick *et al.* 2005) compared with people who did not
- participating in and enjoying activities (Dabelko-Schoeny and King 2010)
- having a lower income - receiving Pension Credit (Caiels *et al.* 2010)
- being younger (≤ 70 years) (Fawcett 2014)

Kuzuya *et al.* (2006) found higher survival among women, those who were less disabled (ADLs), were suffering from depression, did not have dementia and who used a visiting nurse service. As mentioned earlier, almost half of attenders in this study had dementia.

³ Shorter-term attenders were also studied, for example measuring outcomes 90 days after starting or after six months.

People who ate lunch at centres '*perceived less support from friendship and poorer physical health ... than those who did not*' (Fitzpatrick *et al.* 2005:30). It was not known whether eating lunch was their only activity there.

4.8 Discussion

This section summarises this review's findings, discusses the limitations of the literature and draws attention to gaps in the knowledge.

4.8.1 Summary of findings

There is evidence that attending a day centre can benefit older people's mental health, social life and quality of life, not only through attendance alone but also by participation in the various programmes implemented at them.

This chapter has outlined outcomes of the types of interventions that may be found as general activities, and also innovative interventions, in day centres, and of relationships with the health and the social care system. Some interventions were delivered as pilots or to test feasibility. Some of the targeted interventions showed a significant and positive impact. Although some may easily have taken place elsewhere, in terms of accessibility, both physical and to the relevant target group, centres seemed to be convenient pre-existing community venues in which to deliver general or targeted interventions. This may be especially relevant to rural areas where distances travelled are greater.

Their congregate nature appears to contribute to outcomes. The day centre has emerged as, potentially, a gendered service for the older old from lower socio-economic backgrounds and whose health has begun to decline. The literature suggests that day centres may play a variety of roles, and there is more evidence about some of their purposes than others. Most of the literature directly about day centres is not from the UK making comparisons difficult.

4.8.2 Limitations of the literature

The research is as diverse as the types of day centre covered by the literature. That the majority originated from outside the UK adds to the challenges of drawing conclusions given the variety of operational and funding models. From their review of the literature about the effectiveness of day centres for disabled older people, Gaugler and Zarit concluded that '*the literature on adult day care is diverse in terms of focus, design and client population. Therefore, deriving conclusions is difficult*' (Gaugler and Zarit 2001:44), and this remains the case.

A small number of literature reviews were published from 2005-2017, some of which included literature that was pre-2005 or about people with dementia or their carers, therefore fell outside the scope of this review (Shaw *et al.* 2009, Fields *et al.* 2012, Orellana 2011, Mason *et al.* 2007a,

Mason *et al.* 2007b). The only relevant review of UK literature (Manthorpe and Moriarty 2014) focused on access to services from an equalities perspective. One article, of research addressing the pertinent questions of perceptions, attitudes and experiences (e.g. how decision to attend was made, how they spent their time before attending, what satisfied them most and least about the centre, experiences of attending and their relationship with staff), reported only the impact of social contact on wellbeing, and was excluded as participants belonged to a minority ethnic group with specific characteristics (e.g. tended not to be acculturated, visit the GP or hold private health insurance) (Valadez *et al.* 2006).

Most of the literature concerned US centres where models of operation and funding are very different to England, hence some findings might be treated cautiously. There was more English literature not focused on day centres than focused on them, and nothing about interventions tested in English day centres.

Some studies examined several types of service and, whilst mentioning day centres, did not clearly differentiate between the outcomes of each service and, consequently were excluded by this review. For example, a systematic review of respite care interventions highlighted this as a problem in drawing conclusions (Shaw *et al.* 2009), and a study of types of service that impacted on carers' satisfaction with support services discussed different elements of service offers without associating these with specific services (Savard *et al.* 2006).

The majority of literature was published in academic journals, most commonly gerontological journals, with about half as many in geriatric or health journals. Some appeared in social work, social care or public health journals, a few in other specialist topics (e.g. activities) and only one in a social policy journal. Findings, therefore, are likely to be inaccessible to centre providers and professionals working in health and social care unless their organisations employed staff to review academic literature and issue staff briefings. I had expected searches, particularly on websites and in online databases, to identify more grey literature which may complement research, but it is possible that this remains unpublished or unavailable in the public domain as it may contain business-sensitive data, or does not exist to the extent I believed it would.

Findings were not always generalisable to broader populations due to small numbers, participant characteristics, study design, specific centre model or varying systems between countries. Notwithstanding, many findings were reported to be consistent with previous research and findings of qualitative and quantitative research appear to complement each other. Sample sizes varied greatly, with secondary data analysis tending to have larger samples. Numbers of participants ranged from six to 30 in qualitative studies involving interviews or focus groups, and 225 in one using a postal survey.

Mixed methods were used in only one study. However, findings were fully reported only in the report to the funder and not in the published article in this review (Fawcett 2014). That there were few longitudinal studies was unsurprising since cross-sectional analysis was the most used design in quantitative analysis of social science data on ageing from 1946-2000 (Ferraro and Kelley-Moore 2003). However, some studies were 'shortitudinal' with follow-up taking place often at 3-4 months, going some way towards establishing change, although establishing causality may remain problematic. Longitudinal qualitative studies would be interesting to explore, rather than measure, change, since one's perspective may change over time as may recollections of situations or feelings. Case studies may be another useful method for exploring situations in depth, but only two studies used this research design.

Some limitations concern outcomes measures used and data requiring statistical analysis. Profiling attenders may also help day centres identify previously unknown characteristics which could support marketing activities. However, statistical calculations of data (e.g. what more regular attendance is associated with) necessitate expertise which day centres are unlikely to have readily available. Likewise, while some outcome measures used were relevant to day centres' overall aims, others related to interventions undertaken in them. Most required expert administration or equipment, analysis and interpretation, such as by specialist health professionals or researchers. As English day centres are either part of social care or operate independently and are often staffed by volunteers rather than multi-disciplinary teams, implementing similar, mainly health-related, measures would require visiting or bought-in specialists, likely to be unfeasible financially as well as requiring relationships with relevant health teams. The lack of reported interventions undertaken in English day centres suggests these may be uncommon, or that premises may be unsuitable. While larger samples are usually considered necessary for determining statistical significance of results, some studies with smaller samples did report on statistical significance (e.g. Ota *et al.* 2014), suggesting this need not be a hindrance despite restricting complex analysis (e.g. Dabelko-Shoeny *et al.* 2010). Recruiting larger samples may be easier in countries recognising day centres' systemic role, or in centres that are larger or have high attendance levels. Measures that can be administered and interpreted by lay people (staff and volunteers) and are pertinent to the service being offered may be of more practical use to day centre management and operation, particularly if measures correspond with centres' overall aims. Determining the significance of results may be for the purpose of demonstrating the worth of interventions to funders, but interventions yielding results that are not statistically significant may still benefit attenders (Dabelko-Shoeny *et al.* 2010).

Attrition from studies due to poor health, or other caring responsibilities, adds further complications. Given the available evidence about the characteristics of attenders, it is not clear if high attrition rate is indicative of the presence of co-morbidities, frailty and general declining health, or because day centres fail to support wellbeing, or because they do not meet expectations, or because the studies' requirements were too demanding. Certainly, the apparent profile of attenders may constrain research design.

Findings of some research may have been biased. Socially desirable responses may have been given by attenders (Dabelko-Schoeny and King 2010) particularly in interviews conducted at day centres (Iecovich and Biderman 2013a). This is a potential hazard in any qualitative research about day centres since older people tend to be appreciative of services they use and may worry about these being withdrawn.

Certain models of day centre have been the focus of research more than others. More is known about US senior centres than centres supporting those with more functional limitations or that may receive funding reimbursements (Sanders *et al.* 2009).

4.8.3 Gaps identified

There is a substantial gap in the literature concerning how day centres are perceived. It is not known what views current attenders held beforehand and whether these have changed. The perceptions of individuals, commissioners and professionals who signpost or refer may have implications for the future of day centres, including the commissioning process. The views of national statutory and regulatory bodies are missing from the literature (Sanders *et al.* 2009). Although English day centres are not currently required to register with the regulating body, the Care Quality Commission, they have needed to do so in the past, with its predecessor organisation, and may in the future.

Carers and volunteers are absent from the literature. The search identified little about outcomes for carers of attenders without dementia, and nothing about carers' characteristics or their perceptions of day centres. Many English day centres are run by the voluntary sector and are staffed by volunteers (Hussein and Manthorpe 2014) but no study has addressed who they are, what they do there and whether they benefit from volunteering.

The literature on outcomes has focused on change and maintenance/prevention outcomes for attenders, rather than process outcomes.

Often missing in the literature are details of how long or how often people stayed at day centres which may, in part, may be related to type of centre and funding arrangements.

A lack of policy-related theory was notable. Some studies set their findings in conceptual frameworks or used theory to interpret their findings, but these tended to be very specific (e.g. Savard *et al.* (2009) examined attendance patterns using an enhanced version of Andersen's Behavioural Model). Some studies were tangentially related to ageing in place, by focusing on preventing circumstances that would lead to reduced independence or a care home move, for example, but these were mainly specific interventions.

This review found that day centres may be one of several convenient community venues for targeted interventions (e.g. exercise for specific purposes, psychosocial group work), either by trained lay people or by health or social care professionals. Positive outcomes of attendance and interventions, cost-effectiveness and cost savings have been documented. However, the possibilities for centres as preventive services appear to be under-researched and the nature of day centres' structural relationships with community, primary and secondary care services not well-documented. Indeed, very few studies involved managers of day centres or their staff.

One difficulty is isolating the impact of day centres from other interventions or contexts. Yet evidence on the context in which day centre attendance takes place is lacking, for example, what triggered attendance and whether attenders receive support from social networks and/or other parts of the social care system. Data on attenders' frailty levels and wellbeing are also absent. This is important data for the contextualisation of outcomes. Although, the outcomes measurement tool developed in day centres aimed to isolate the impact of a service (Caiels *et al.* 2010) - one version of which is used annually by local authorities with people whose receive local authority funded or commissioned services - this review did not find evidence of use of the finalised tool in day centres. However, even its administration would not explain what it is about day centres that people like which, to an extent, is also missing from the literature.

The paucity of literature about day centres as whole entities may be linked with the fact that a day centre is essentially a building in which a variable set of services takes place which makes them inherently difficult to research.

4.9 Strengths and limitations of this review

This review's strengths are the systematic approach taken and that it is based on detailed and broad searches which identified more literature than expected, much of which has been included. Limitations of the literature are acknowledged due to a non-scoring approach being taken.

The review was limited to English language material. Literature may not have been identified due to differing terminology although efforts were made to allow for this. There may have been other potentially productive literature sources that were not identified.

4.10 Conclusion

From the lack of research about English day centres, at least three conclusions are possible. First, their role may be less clearly defined in the UK than in some other countries (e.g. US) where undertaking research may be more straightforward with set models of day centre and national support organisations. Nonetheless, in a book about long-term care in an ageing society, the shortage of research about U.S. day centres is emphasised, particularly their financial benefits and *'what services make a difference to whom and under what kinds of situations'* (Dabelko-Schoeny *et al.* 2016: 196). While Dabelko-Schoeny *et al.* argue that knowing this is critical for the future of day centres, they suggest that the focus might be specifically on people with dementia or learning disabilities. Second, there may be limited funding. The current UK financial situation may have contributed to limited capacity and funding for social care research both in local authorities and the independent sector (Rainey *et al.* 2015). Social care research has relatively limited funding and capacity, compared with other research sectors (Marsh and Fisher 2005). Third, in 2001, it was suggested this may reflect low priority given to this service model by both policy-makers and researchers (Clark 2001). With current scarce resources and a focus on in-home support and personalisation (discussed in Chapter 2), this may be even more the case.

Chapter 5 Case studies of four day centres

This thesis aims to paint a rich picture of four day centres in the environment of 2014-2017. This chapter begins this process by presenting case studies of the four participating day centres. These set the scene for the perspectives of centre managers and local authority participants about centres' current and potential future role and purpose (Chapter 6) and the outcomes of involvement with these centres by attenders (Chapter 8), family carers and day centre staff and volunteers (Chapter 9). A whole chapter is dedicated to these case studies since similarly detailed data about centres is absent in the 2005-2017 published literature (see Chapter 4), thus obscuring their activities and resources.

This chapter opens with an overview of the participating day centres. Case studies appear in sections 5.2-5.5. Each starts with a brief overview of the locality in which the centre is located and its population. There follows a description of the provider, premises, centre aims, charging and funding, the fieldwork visit day's structure, staffing and any links with the local community, voluntary organisations, social care and health services. Target users and centre capacity with attendance details on the visit day are also stated, and the entire current attender group is described where managers provided this data. Each finishes with a narrative description of the day and notes about the buildings. Case studies are based on diary notes made during fieldwork, interviews with managers and background documentation provided by them. A summary concludes this chapter.

5.1 Overview of day centre case studies

Some compromises were necessary in recruiting day centres across the full matrix of typologies (see 3.2.2) and across political administrations (see Table 7). Reduced numbers of centres operating and lack of information, for example, meant it was challenging to identify centres in different political administrations. Consequently, some typologies are not represented, such as very small, entirely volunteer-run day centres that were not affiliated to a national body.

Table 7: Matrix showing met and unmet elements of day centre typologies and political administrations

Typologies					Political administration (3 major parties)
Ownership	Building designation	Admission criteria	Size	Clientele	
√ Council √ Voluntary √ Housing association x Private	x <i>Standalone</i> √ Multipurpose √ Purpose-built √ Adjoining sheltered/ extra care housing √ Religious affiliation or building	√ Local authority referrals only √ Open access √ Mixed	x <i>Large</i> √ Medium √ Small	√ High support needs √ Socially isolated √ Needing transport √ Religious affiliation	√ Conservative √ Labour x <i>Liberal democrat</i>

Characteristics of some centres changed between initial contact and fieldwork. One had been large (≥ 35 attenders daily) and had become medium-sized (20-35) and two had been medium-sized and had become small (≤ 20)⁴. One had been initially understood to be a standalone building, but it transpired that the housing estate where it was located included ‘sheltered’ flats directly above the centre. However, it was not formally linked to these.

Table 8 outlines the main characteristics of the day centre case studies relative to typology of day centres presented in Chapter 3 (3.2.2), their operating days and the local authority’s political administrations.

Table 8: Overview of day centre case studies

Day centre	Typologies				Operating days	Local authority political administration
	Provider	Building	Admission criteria	Size at time of recruitment / research		
DCHA	Housing association	Ground floor of extra care housing	Local authority referrals only	Medium / small	5	Labour
DCLA	Local authority	Purpose-built centre adjoining sheltered housing	Local authority referrals and drop-ins for activities and/or lunch	Large / Medium	5	Labour
DCV1	Voluntary sector	Church hall	Open	Small / small	1	Conservative
DCV2	Voluntary sector	Multipurpose community hub	Mix (open and local authority referrals)	Medium / small	2	Conservative

The following four sections present the day centre case studies.

⁴ These size groupings were devised for this study.

5.2 Housing association day centre (DCHA)

5.2.1 Area profile

Location characteristics: Deprived urban district close to former heavy industry site and near large council estates. Area is being developed and increasingly gentrified. A university is located nearby. DCHA is near a busy road of shops.

Local authority population: Just over 275,000
9% aged ≥65 years
53% white
74% white among ≥65 group
(Office for National Statistics 2011)

5.2.2 The provider and premises

A housing association provides this day centre on the ground floor of an extra care block of 40 flats, built at the turn of the millennium. Building entry is by numeric keypad or by ringing a bell. In the communal reception area are armchairs, a fish tank, a kitchenette with chairs around small tables for residents and their visitors, a water cooler, a vending machine and doors to a hairdressing salon (used weekly by a self-employed hairdresser) and a bathroom with a hoist. Beside the main office door is a board with staff photos, names and roles and a Consultation Room.

Along the wide corridor leading to the day centre's dining area are two upholstered armchairs beside a coffee table on which is a plant in an attender-made pot-holder. Adorning windows to the lounge directly opposite are strings of attender-made bead art. Three areas of the centre can be separated by folding doors, which are left open. Nearest is the television lounge area. Off this is the care staff's small office on the door of which are displayed the bingo schedule, advertisements for upcoming events and entertainment (e.g. theatre performers, clothing sale) and The Dignity Charter (provider's statement concerning staff commitments). Upholstered armchairs with soft cushions are arranged around two coffee tables, with more in a row facing the television and a further two beside a small coffee table by the window on which are displayed the local Pensioners' Forum newsletter, leaflets and newspapers. There is also a goldfish tank. Next is the recreational part of the lounge, with wooden tables and plastic padded wooden chairs, cupboards for equipment, a small pool table and a table tennis table. Cupboard surfaces are full. After this is the dining room, also used by residents. Each area has double fire doors to an accessible, paved garden with benches, tables and chairs. Beside the far doors are a corner table, from which after-lunch and mid-afternoon refreshments are served, and a kitchen. The larger kitchen in which lunch is prepared is on the opposite side. Both single-sex and large unisex accessible toilets are at the farthest end, off a lobby decorated with artwork. More toilets are off the corridor. One has a ceiling track, but attenders need to bring their own sling. Currently none need this.

Windows to the garden run along one side. The centre is very bright and colourful, having been redecorated directly before fieldwork. Pale green carpet is in the lounges and dark vinyl in the dining area. Curtains, chairs and cushions are green and magenta as is the flowery wallpaper at the far end.

The activity room, on the other side of the corridor, has tables set up in U-shape. There is a sink with storage; four tall free-standing cupboards and open shelves decorated with artwork made by attenders (e.g. Easter bonnets, plastic stained glass). It also houses a sewing machine and a football table. Chairs are wooden with arms, colourful padded vinyl seats and backs. Clip-on tables are available for wheelchair-users.

5.2.3 A description of the day centre

Box 4 provides an overview of DCHA's aims, users, capacity, operational days, charging and funding, structure of the day, meals, transport, activities, staffing and links with the community and voluntary organisations and health and social care. A narrative description of the day follows.

Box 4: Overview of DCHA

Aims	
Paperwork concerning the aims of DHA was not provided. According to the provider's website, its day centres aim to 'offer the chance to join in social and creative activities, meet new friends, visit places of interest, get advice and support and learn new skills and hobbies.'	
Target users, attenders and capacity (research day)	
Older people with eligible needs (social isolation and needing support with personal care and transport) referred by the local authority.	
Registered: 14 (2 were absent for entire fieldwork period).	
Attendance during fieldwork: 9-12 (12 reported at time of centre recruitment and 10 were expected to join).	
The research day was reportedly the busiest day, with attendance at 6-7 on other days.	
No anonymised overview data about current attenders was provided.	
Attenders are referred to as 'customers'.	
Operation	
Five weekdays.	
Charging and funding	
Lunch £3.50 subsidised until the end of the contract period; full charge will then be £6.	
Charge £38.94 per day. Self-funders are invoiced in arrears by the local authority. Places are held for 6 weeks.	
Refreshments £1, collected by staff in the morning. The excess goes into a fund administered by attender committee (remaining from the days when the centre was a 'club'), used for extras e.g. entertainment, parties.	
10-year block funded contract (i.e. not based on actual attendance) with local authority for 20 daily places until March 2017 (£38.94 each place). Manager (seconded) reported not always having sight of the centrally-held budget.	
According to a February 2015 local authority day centre review document, annual costs were £304,300 without transport.	
Structure of the research day	
10:00-16:00	Operational time (6 hours)
10:00-10:15	Arrival and seating in television lounge area
10:15-11:00	Tea/coffee/toast in dining area
11:00-12:00	Led group activities (themed art/craft in activity room or baking in the small kitchen in groups of 3, maximum of 1 wheelchair).
12:00-13:00	Lunch in dining area
13:15-14:15	Led singalong in activity room
14:15-15:00	Self-directed/informal activities in middle area
15:00-15:30/45	Tea/coffee/biscuits/baked items in dining area
15:30-15:45	Bingo in dining area (fortnightly) called by an attender
15:45-16:00	Attenders move to television lounge and prepare to leave; transport arrives and attenders leave at 16:00.

Meals
First four fieldwork weeks: Supplied and heated on site by a meals-on-wheels provider, one of the employees of which circulated collecting lunch choices. Last ten fieldwork weeks: Provided by independent catering company. Part of lunch cooked on site (e.g. chips, vegetables) by its two employees and part (e.g. chicken) transported from provider's main kitchen in insulated crates, arriving at around 11.30. The research day menu was chips or mashed potato with fish, chicken or sausages. Dessert options are not communicated in advance. Served by cook and taken to attenders by staff.
Transport
Local authority minibuses (n=3-4) each seat 10-11 but carry fewer people. They park beside the main entrance. Escorts help attenders inside to television lounge and from lounge to minibus. Provider liaises with transport department to organise but is not involved with charging.
Organised activities
Afternoon self-directed activities were colouring, craft or dominoes, with equipment laid out in advance by staff. On two fieldwork days, afternoon activities were replaced by a musical theatre production and an afternoon tea for a staff member who was leaving. No programme of activities on other days was displayed, available or provided by the manager.
Opportunities for involvement
Regular Service User and Residents Committee. An annual satisfaction survey is carried out and a Complaints Log kept.
Staffing
4 care staff (and a fifth working on different days who occasionally filled in during fieldwork period) 1 activity leader (3 days) 1 Day Care Coordinator (shared role, also involving housing administration and human resources) The day centre manager was on secondment elsewhere with the same provider and the housing manager had taken over centre management. Staff are key workers for named attenders, matched as far as possible based on background, ethnicity, interests etc. following initial assessment. Each has a dedicated 'paperwork day'. There are no volunteers.
Links with the community and voluntary organisations
Two clothes vendors visited regularly. One ran a clothes party in the building's communal reception area. The other brought a selection of clothes from her market stall and ordered colours and sizes on attenders' request.
Links with health and social care
Weekly podiatry on varying days; attenders and residents seen in the Consultation Room. Attenders of different days may request an appointment and are transported in and home on the minibus, thus effectively receiving a free day (according to the seconded manager). Optician visits twice yearly. Audiology visits on request. Community Mental Health Team carries out assessments at DCHA. District nurses change dressings by individual arrangement. Staff arrange hospital appointments and transport. Occasional talks given (e.g. eye health by optician, diet by district nurse).

Attenders all greet each other and staff when they arrive. Staff hang coats up in their small office. Some chat with each other or staff before refreshments are served. Most have buttered toast cut into triangles and served on a square of kitchen paper. Staff ask which hot drink attenders would like and serve these in white cups and saucers. Some attenders bring fruit to eat instead of biscuits, sometimes sharing this. Once refreshments are served, a staff briefing occasionally takes place.

During the morning group activities, staff lay tables for lunch with green melamine table mats, cutlery, glasses, squares of kitchen paper folded into a square as napkins and white ceramic cruet sets. They also set up the corner refreshment area with cups, saucers, milk, flasks of tea/coffee for after lunch. Menus are not displayed, having already been distributed. A few attenders take their own lunch, giving this to staff on arrival for storage in the fridge, which staff heat up as necessary.

One takes a small salad to eat with her meal. Some residents (n=11-12) join the group for lunch. The extra care staff's role includes serving non-attender residents but they did not appear during fieldwork, leaving centre staff to cover. Staff serve disposable plastic cups of water or juice with lunch. After lunch, staff use a wall-mounted two-way radio to call extra care staff to collect residents.

The day is quite structured, but not everyone joins the organised activities. The television is left on all day for attenders who wish to sit and watch it. Table tennis, pool and table games can be played on request. One attender prefers to sit outside and knit, do crosswords or watch sport on her iPad. Another, who is blind, spends the morning in the recreational lounge, occasionally chatting with staff, but joins in afternoon activities and chats with co-attenders. The only man, who is severely cognitively impaired, spends most of the day at the dining table, in the same seat, sometimes looking at the paper, correspondence he has brought or he naps. During fieldwork, he played dominoes with staff once, table tennis with staff once, joined the singalong once and visibly enjoyed the theatre production.

Music is a big part of this centre. A large speaker in the recreational lounge plays music - usually from the 1950s, 1960s or reggae - all day at relatively high volume. Some attenders sing along. Some dance leaning on their walkers on the way to the dining table for afternoon refreshments. The well-attended organised singalong is usually themed, and the activity leader shares facts about songs' meanings, the singers or asks attenders about the songs and any memories they may have of them. Throughout the day, staff circulate with jugs of water.

Most attenders interact with each other and staff, some calling across the room to greet others, ask how they are or make jokes. The manager was the focus of some risqué song-based⁵ banter one week when he popped in to greet people. The Day Care Coordinator was warmly welcomed when she regularly appeared. No fixed seating arrangements are allowed after this was noted to cause conflict. Afternoon activities are accompanied by much conversation. Attenders clamour if afternoon refreshments are not ready by 3pm sharp. Biscuits are offered from tins and served with tongs or items baked by attenders in the morning are shared.

Attenders' reduced mobility and disabilities mean staff are constantly assisting people to stand up from their chairs, taking them to and from the toilet, handing them their bags and helping them organise their money, ensuring the blind attender knows where her drink and biscuits are and assisting her to feel part of the activities. They take protected lunch breaks behind closed doors.

⁵ Are You Lonesome Tonight (Elvis Presley)

Nail filing and painting are available on request from staff at no extra charge.

Observations about the building

Residents may eat lunch in the dining room between 12:00-13:00 and, for a small fee, may also join the group for afternoon refreshments and bingo. Some residents who attended the centre on other days wandered in at other times on non-attendance days and demanded staff attention. This was a recognised problem and the manager reported planning to speak to the three cognitively impaired people about this; however, given their cognitive impairments, doing so would be unlikely to result in long-term change. The centre feels homely, comfortable and welcoming.

5.3 Local authority day centre (DCLA)

5.3.1 Area profile

Location characteristics: Urban centre located in a residential area midway between two district High Streets, 300 metres from one and 500 metres from the more affluent one.

Local authority population: Just over 200,000
11% aged ≥65 years
66% white
84% white among ≥65 group
(Office for National Statistics 2011)

5.3.2 The provider and premises

A local authority owned and managed 'resource centre', DCLA was purpose-built in the 1970s. Its operation was previously contracted out to a voluntary organisation for some years. Over the years, its name has changed from Club to Day Centre to Resource Centre. It is at the edge of a local authority housing estate which incorporates a small number of sheltered housing flats (17 units) directly above the centre which have their own entrance. These were not exclusively for older people until 2016. The centre was refurbished nine years previously to the manager's specifications (e.g. high toilet bowls, wall bars on either side of cubicles, different width cubicles to cater for different needs, such as people with a short reach, with walkers or who need assistance). Entry is via a bell answered by reception staff. A staff office with a reception desk and a 'Signing In and Out' book, a leaflet stand, two sofas and a large fish tank and a leaflet stand are directly beside the front entrance. Beside the fish tank are a list of staff names, job titles and the centre's 'mission statement' (purpose). The office also housed a trainee social worker on placement during the fieldwork period.

The main area, the Dining Room, is ahead. Groups of tables with plastic-padded wooden chairs are in this large L-shaped room which also has a dedicated jigsaw table, a table displaying games, shelves with more games, books and playing cards, a pool table, a table tennis table and a plastic-cushioned two-seater sofa. Directly off the Dining Room are an arts and crafts room (with a piano), a computer room, a conservatory - which adjoins the managers' office and a small meeting room with a kitchenette (the Bar Room) - separate groups of single-sex accessible toilets, a television room, a quiet room with books and videos on shelves, a treatment room housing a hair-washing sink, a bed, lockers and a massage table and a large kitchen with a serving hatch to the dining room. Chairs in the television and quiet room are fabric-upholstered. Down a small corridor is a small office, a Rest Room with a bed attenders use if tired or feeling unwell and a Bathroom containing a toilet, an accessible bath and a changing table. Through this is the laundry. At the far end of the Dining Room is the back entrance to the car park where the transport parks to drop off and collect attenders. Beside it is a wheelchair bank. There are mobile hoists in the Rest Room

and the Bathroom. Off the Dining Room, and visible through full-height windows, is DCLA's accessible garden. A noticeboard near the kitchen displays announcements (e.g. Service User Meeting dates, new poetry reading group) and noticeboards by the front and back entrances display regular activities for week.

5.3.3 A description of the day centre

Box 5 provides an overview of DCLA's aims, users, capacity operational days, charging and funding, structure of the day, meals, transport, activities, staffing and links with community and voluntary organisations, health and social care. A narrative description of the day follows.

Box 5: Overview of DCLA

Aims	
To:	
<ul style="list-style-type: none"> • develop preventative services to enable people to live in their own homes wherever feasible and possible • provide rehabilitation, personal and physical care when needed • develop the service users' potential by offering classes and sessions to enhance physical and mental skills • enrich the service users' quality of life by offering leisure activities and opportunities for socialising • act as a resource for service users, their families and the local community • offer support and advice, referring on and signposting when appropriate • provide support and respite for older people and their carers. 	
Target users, attenders and capacity (research day)	
Older people with eligible needs referred by local authority.	
Capacity approximately 25 at current levels of need and with unchanged staffing levels. Building capacity considerably higher.	
It is also open to drop-in users, people who are self-sufficient and without eligible needs. Up to 10 daily were observed to join the group for lunch.	
Attendance during fieldwork (observed): 22-28 excluding drop-ins (40 reported at time of recruitment, including drop-ins). Centre records showed average attendance during research as 30, ranging from 23-34. This included drop-ins. Numbers registered and due to attend ranged from 46-56. Age bands of those registered to attend on the research day (n=46) were 60-69 (n=5), 70-79 (n=15), 80-89 (n=15), 90-99 (n=10) and 100+ (n=1). Two-thirds were female (n=30) and one-third male (n=16).	
During fieldwork, 6 people stopped attending due to a move to a care home (n=2), moving away (n=1), death (n=1), behavioural issues (n=1) and for unknown reasons (n=1). Another was absent for most of the fieldwork period due to illness.	
The number of fully or partly self-funding attenders (with eligible needs) was said to be very low, but the manager only knew how attenders paid if they had told her.	
Atenders are referred to as 'service users'.	
Operation	
Five weekdays.	
Charging and funding	
£25 per day. Atenders are invoiced in arrears by local authority. Charges are made for lunch (£4.10), 20p for tea, 25p for coffee (referrals). Transport is not chargeable, but is only for people with personal budgets (i.e. assessed needs). Payment due for non-attendance; place can be held and not charged-for in special circumstances (e.g. 8 weeks planned cancer treatment).	
Drop-ins: £2 per session (maximum half day).	
Funded by local authority held budget. 2015-16 expenditure £679,588 (22-4-16) without transport.	
Structure of the research day	
09:30-14:30/10:30-15:30 Operational time (5 hours)	
09:30&10.30-11.00 Arrival, refreshments, toast on request	
11:30-12:00	Seated exercise class run by staff in arts and crafts room
11.00-12.15	Falls Prevention Exercise Group run by NHS-employed postural stability instructors in conservatory – for people referred by NHS and registered attenders
12:15-13:15	Lunch
13:30-14:30	Memory exercises in the Bar Room
13:30-14:00	Refreshments (including biscuits) served from refreshment trolley by kitchen staff (wherever attenders are)
14:30-15:00	Healthy Eating session in the Bar Room

14:30 & 15:30	Transport arrives. Staff collect attenders from rooms, assist them to get ready and attenders leave with escorts
Meals	
Prepared on site by 3 kitchen staff in the large, well-equipped kitchen that incorporates heated serving containers adjoining a serving hatch. A 5 week three-course menu rota (displayed beside the kitchen hatch) operates. Lunch includes soup, a hot fish/meat/vegetarian option or a choice of salads or baked potato and a hot dessert. Specific dietary needs can be catered for on request.	
Transport	
Local authority accessible transport minibuses (n=3), each carrying fewer than the number of seats. Drivers and escorts arrive about 15 minutes early and help people to the minibuses. A few attenders organise their own transport.	
Organised activities	
Timetabled staff-run activities on other days: crafts (including knitting), quizzes, singing, relaxation, tai, chi, seated exercises, bingo, Scrabble competition and other board games, discussion group, music appreciation, circle dancing (for attenders with dementia only), Stroke Group; manicures on request. Externally-led activities: chair-based exercises, pet therapy (fortnightly), art, reading group. A hairdresser visited fortnightly. Blood pressure checks and computers/tablets are available on request on any day. On one fieldwork day, a staff member from the sister centre visited to learn from practice at DCLA with the aim of improving activity uptake which is low there compared with at DCLA. She met the Senior Care Worker about this and joined the memory exercises class as an observer.	
Opportunities for involvement	
Monthly Service User Meetings on different days. Dates displayed on noticeboard. Suggestion box beside hatch to kitchen. Biennial quality survey.	
Staffing	
Assistant manager, receptionist, Senior Care Worker who manages 3 Care Workers. Manager manages this and another LA run centre and is based at DCLA once a week. Three kitchen staff deal with all crockery and cutlery. Staff are local authority employees. One attender-facing volunteer and one office volunteer.	
Links with the community and voluntary organisations	
Weekly art activity run by local college. Monthly hearing aid maintenance/battery changing in small meeting room provided by Action on Hearing Loss. A group of older people, service users, family carers and volunteers that aims to improve the quality of life for older people in the area and beyond is based at DCLA and holds meetings and occasional events there. A computer Adult Education class was advertised during fieldwork but ceased due to low numbers (minimum required 12). The Stroke Group has been recognised by the NHS. Its 2016 annual health and wellbeing day, during Action on Stroke Month was run in partnership with local carers organisation. Nearby Sure Start centre and private nursery visit occasionally; centre acts as fire point for nursery. As an online centre, free internet access is available, advertised by the Council, the local Citizens Advice Bureau and local Age UK.	
Links with health and social care	
Weekly chair-based exercises run by the local authority Active Health Team. Reading group run by student social worker. Occasional talks given by health professionals (e.g. dementia, hearing). Falls Prevention Exercise Group run by NHS-employed postural stability instructors and organised by the Integrated Primary Care Falls Service (no payment made for room use). Operational for more than 10 years; group used to be daily and is now weekly. District nurses use Treatment Room for daily insulin injections for one attender. Blood tests, changing dressings etc. are arranged on an individual basis. The manager set up this arrangement so that attenders did not miss their attendance days for health appointments. No payment made for room use but health centre where district nurses are based has a clinical waste contract to collect from the Treatment Room. Good relationship with health centre they are based in. During fieldwork, an optician visited to check that an attender's new reading glasses were satisfactory after being unable to contact her at home. NHS Rehabilitation Team visited during fieldwork to assess an attender who was progressing from a walker to a stick after a long hospital stay. Good relationship with this team which also occasionally arranges for centre visits for people in their temporary care (at the team's expense). Staff arrange podiatry and audiology appointments. Good relationship with local GP medical centre, mainly via Senior Care Worker. Staff call (with permission) to make appointments and/or GPs visit centre if concerned attender has e.g. chest infection/urinary tract infection. A group of 8 first/second-year student doctors from a university visit once weekly for 12 weeks and spend the day speaking to attenders about them, their health and their lives. Staff give them a lecture about day care and dignity. There are two sessions per year. Payment per student is received.	

The centre hosts social work students on placement, providing desk space in its office and allowing them to accompany staff on assessment visits etc. One started on the second fieldwork day. Occasional attendance at Case Conferences and Best Interests Meetings (e.g. about safeguarding matters).

Attendees greet each other on arrival after they, or staff, hang coats up on one of three coat-stands in the dining room. Background music of varying genres plays from a small speaker beside the kitchen for most of the day. Overall, the day is very relaxed. There is a loose structure based around timetabled activities. Games (e.g. Scrabble, dominoes, playing cards), books, jigsaws, a pool table and a table tennis table are available to be used as people choose, and people move between rooms.

A staff member circulates, before 11am, asking people to choose their options from the menu chalkboard beside the serving hatch. 'Drop-ins' submit their choices in writing in advance. The volunteer circulates and chats and runs small errands for attendees (e.g. buying aftershave). Staff circulate reminding people individually that activities will be beginning about 10 minutes beforehand. Those not joining in with organised activities remain in the dining room and chat, play dominoes, cards or Scrabble, do jigsaws, read the paper or use tablets to, for example, follow the news in another country on a tablet computer or listen to music. A pool table and a table tennis table are also available. Throughout the day, staff circulate chatting with attendees and provide assistance as needed. Activities start and end on time. Programming appears to have incorporated 'movement' time between rooms and toilet visits.

Staff and the volunteer set tables for lunch (cutlery, folded napkin, plastic tumblers, jug of water and condiments – usually salt, pepper, salad cream and ketchup sachets with vinegar on fish and chips days) during the morning activity, setting places where people have been sitting. Some attendees are seated at the tables while staff are setting them. Non-slip silicone mats are provided to keep plates in place for those who need these and some also have adapted cutlery and crockery. Some attendees wear plastic aprons. Meals are served by kitchen staff and served to attendees by staff and the volunteer. At least four attendees need individual help with eating. Jugs of water are available on tables and meals are served by option (i.e. first meat/fish then vegetarian, etc). Attendees help each other open condiment packets. Staff assist attendees with more advanced dementia, all sitting at one table, to eat. People may drop-in for an activity or visit for lunch; between three and ten people dropped in for lunch there each week during fieldwork. Although encouraged not to stay more than half a day, some stay for most of the day. Staff monitor such people and, if necessary, have a conversation with them about their needs to decide whether to organise an assessment. Staff and the volunteer collect crockery and cutlery in a trolley with a food waste bin. Lunch is unrushed (a managerial requirement) and afternoon activities do not start immediately. After lunch, around five attendees go straight to the television room. Some spend the afternoon there while others join the activities. One has a short nap in the quiet room before

joining the memory exercise class. Occasionally, when activities are cancelled (e.g. due to continence 'accidents' needing the attention of several staff), people gather together and play cards. Occasionally, a Spanish-speaking volunteer was said to drop by to chat with an attender who had had a stroke and who had started to speak in a mix of English and her native Spanish.

Flowers are placed beside the hatch to the kitchen in memory of any recently deceased attenders. This happened once during fieldwork; attenders stood beside the flowers and talked about the person.

Before attenders arrive, staff meet in the office to discuss plans for the day and attender updates. Once attenders have left, there is a quick de-brief in which they share any observations, concerns or evaluations of how the day has been. Staff breaks are sometimes cut short if there is a staff shortage.

Observations on the building

This very large and well-equipped building is very much under-used. It is accessible, secure and feels very welcoming. The hill from one high street is steep but from the other it is level. Any fabric-upholstered chairs that suffer continence 'accidents' are steam-cleaned by staff on site.

5.4 Voluntary sector day centre 1 (DCV1)

5.4.1 Area profile

Location characteristics: Town with population of approximately 18,000. The area covered is one of socio-economic extremes. Proportion of households in town owning own home outright was below the regional average of 32.5%; 21.8% of property was rented social housing. DCV1 located 200 metres from town centre.

Local authority population: Just over 130,000
16.4% aged ≥65 years
91% white
97% white among ≥65 group
(Office for National Statistics 2011)

5.4.2 The provider and premises

This day centre is one of several services provided by the local arm of a religious-based national charitable organisation. It serves three of the four main towns in the local authority and their surrounding localities. Twelve years prior to fieldwork, its operation transferred from the church to its current provider. Over the years, its name has changed from a Club, to a Day Centre and, during fieldwork, back to a Club. The latest change, which was communicated via a newsletter notice, was explained as follows:

‘We think that this gives a clear idea of the friendship and entertainment given and received but sounds more “up-to-date” and “with it” – in keeping with the Members!!’

The local provider has been operating since 1997, a fact about which its parent organisation is proud. The parent organisation regards it as a flagship and sends staff on learning visits.

DCV1 operates in a church hall. The building, constructed in 1992, comprises a church, a hall with a stage, a kitchen with a serving hatch to the hall, four meeting rooms, a café (opens twice weekly), a vestry, the church office and the charity's office. It is fully accessible throughout. The long, rectangular hall adjoins the church's main worship area via a folding partition wall. As an extension to the main church, the ceiling is very high. Three big, high windows with blinds at one end and three small ones at the other means the room is very bright and airy but is not cold. Toilets, used by anyone in the building, are across the lobby through the main entrance door; one is accessible and unisex.

Members arrive to a hall that has been set up by a volunteer and one ‘active member’ (see Box 6). Near the entrance is a coat rack. On one side, there are three trestle tables laid out at different angles for lunch and dressed with flowery vinyl tablecloths, small blue vases with artificial daisies, cutlery and flowery plastic tumblers containing a folded napkin. On the other side, near the stage, is a semi-circle of fabric-padded wooden chairs with small, folding tables in front of pairs of chairs.

In front of the kitchen hatch is a tea trolley with patterned cups, saucers and mugs as attenders have different preferences of cup size.

On the stage is the day's paraphernalia, including the register of comments, suggestions and complaints, a 'Signing out book' for attenders who leave early or pop out during the day (e.g. for appointments or shopping), games and boxes of magazines.

Displayed on the noticeboard beside one of the entrance doors is a three-month programme of activities, which is also given to everyone in advance.

5.4.3 A description of the day centre

Box 6 provides an overview of DCV1's aims, users, capacity, operational days, charging and funding, structure of the day, meals, transport, activities, staffing and links with community and voluntary organisations, health and social care. A narrative description of the day follows.

Box 6: Overview of DCV1

Aims	
Provider aims: to reduce social isolation and promote mental and physical wellbeing; to enable its members to continue living at home whilst enhancing their quality of life (in cooperation with other agencies).	
Target users, attenders and capacity (research day)	
Open access within the catchment area for people of any religion, race or ethnic origin who are aged ≥60 years and housebound, socially isolated and may be in receipt of care from statutory or voluntary agencies. Does not cater for people needing lifting, personal care or nursing, or people needing specialist care for mental illness. Attendance during fieldwork: 12-14 (15-18 reported at time of recruitment). Capacity was said to be around 25 by the manager. Centre records showed that members registered to attend during fieldwork numbered 17. Their age bands were 60-69 (n=1), 70-79 (n=4), 80-89 (n=7) and 90-99 (n=5). Attenders are referred to as 'members'.	
Operation	
One week/day. Closes for three weeks over Christmas and the New Year.	
Charging and funding	
An annual membership fee (£24), payable six monthly, enables DCV1 attendance and use of other services. Attendance is on a planned basis for an additional weekly subscription (£1) which goes towards costs of visiting speaker charges, craft materials etc. Charges are also made for lunch and three sets of refreshments (£4.50) and volunteer driver transport (£3.50). Charges, payable on the day, are unchanged for two years. All attenders self-fund.	
Service Level Agreement with parent organisation of £5,054 annual maximum 2014-2017 (on a basis of 20 weekly attenders, released for actual numbers).	
Annual core grant from the local authority (with Service Level Agreement) for all services provided.	
Office rental cost (approx. £5,000) donated by church, allowing use of hall free of charge.	
Small grants from charitable trusts and donations are received. Fundraising includes 'Friends of' subscriptions and events such as fairs or music evenings organised by the provider or raffles in local pubs organised by volunteers. Donations are acknowledged in quarterly newsletters.	
Structure of the research day	
10:30-15:00	Operational time (4.5 hours)
10:30-11:00	Arrival, tea/coffee/biscuits, lunch information, sale of raffle tickets
11:00-12:00	Whole group activity
12:00-13:00	Lunch
13:10-13:30	Church service (optional extra)
13:30-15:00	Informal small group activities
14:15-14:30	Refreshments (including biscuits or sweets)
14:30-15:00	Transport arrives and attenders get ready to leave
Meals	
A rota of volunteer cooks is operated, displayed on the noticeboard.	

Transport
Providers' volunteer car driver service is used by most attenders. Each driver is assigned one or two named attenders. They collect them from their front door, accompany them into the centre and ensure they get home safely. Some use local community transport organised by the provider; attenders pay transport directly.
Organised activities
A three-month programme of whole group activities is given to attenders and displayed on the noticeboard. During fieldwork, activities included musical and bird bingo, food sampling, a reminiscence talk about life in the 1950s, exercises with a physiotherapist (whose belly-dancing group sometimes gives performances), seasonal arts and crafts led by the Workers Educational Association, singalong music with guitar accompaniment, a talk about key moments during World War II, a performance by a local amateur dramatic group, a Scottish dancing performance and a special occasion lunch. Only bingo and food sampling was led internally. Activities for the next quarter were chatting after the holiday, a beetle drive, a childhood games reminiscence session, yoga, a demonstration by a frozen meals provider and talks given by representative of an armed forces charity, an assistance dogs charity and the local NHS Rapid Response service. In the afternoon, three tables replace the morning's semi-circle of chairs. One has a card game (usually Uno), one dominoes or triangular dominoes and the third colouring books, magazines and word-searches. Attenders sit at their preferred table.
Opportunities for involvement
A4 hardback notebook labelled 'Register of members' comments/ suggestions, complaints and comments to be displayed at day centre sessions, lunch, during shopping sprees, coffee mornings (June 2001)'. An annual satisfaction and feedback survey is carried out for users of all its services. There are separate questions on other services but nothing specific to the day centre. Member and volunteer representatives sit on the local organising committee. Two members are 'active members'; both have a learning disability. The status of 'active member' is assigned by the manager to people who have indicated a wish to be actively involved in providing the service (e.g. by helping to move furniture, purchase items such as milk regularly, help show menu boards). It aims to recognise their contribution. Members donate items for fundraising.
Staffing
The provider employs 5 part-time members of staff covering the office from 09:00 - 15:00 Monday-Friday. Of these, one organises the whole group activity and another is actively involved in providing the service each week. The provider's manager is also the day centre manager. Twenty-five volunteers support DCV1 by supporting attenders during the day, working in the kitchen or as drivers. There are usually 5 volunteers supporting attenders at any one time, more in the afternoon as some kitchen volunteers join in, plus a younger, blind, physically disabled 'conversation volunteer' who is present for the whole day.
Links with the community and voluntary organisations
Links with carers support, and other, voluntary organisations in neighbouring district; signposting between organisations takes place. British Red Cross (based in local hospital opposite social care) signposts people to DCV1 during 6 week reablement period after hospital discharge.
Links with health and social care
Hearing aid batteries for the monthly hearing aid clinic in which trained volunteers maintain hearing aids and replace batteries which are supplied by local hospital. Referrals from Community Mental Health Teams and Community Psychiatric Nurses received. Good relationship with local social enterprise operating NHS community services (e.g. district nurses, stroke clinics etc). Manager is invited to team meetings. Local authority Ageing Well team publicises service. Manager invited to Adult Social Care meetings to speak about service occasionally. Provided 'Message in a Bottle' kits ⁶ to new attenders to be used by emergency services visiting their homes; use of these is not monitored.

Atenders are greeted by volunteers who take their coats before attenders take their usual place in the semi-circle. Walking sticks are considered as a trip-hazard and, once seated, attenders hand their sticks to volunteers to be stored in a holder beside the stage. Walking frames are stored by the stage or coat rack. Volunteers react quickly when members appear to want their stick or frame (e.g. if they need to go to the toilet). Two members are brought cushions from a cupboard

⁶ A small plastic stickered container with medication and contact details for use in emergencies is stored in the fridge door and a sticker placed beside the front door. Emergency services are familiar with these kits.

beside the stage. Attenders chat to their neighbours and volunteers circulate, chatting with people as they arrive.

Once most members have arrived, a volunteer takes the refreshment trolley round offering tea or coffee in cups and saucers or mugs, and another offers biscuits from a tin. Refreshments are placed on the small tables. Another volunteer then circulates showing the day's menu, written on a big chalkboard, to everyone individually, so they know what's for lunch and can decide whether to have it. Occasionally, an attender who objects to the menu is offered an alternative from the supermarket across the road and subsequently chooses the day centre's meal. The board is then placed at the kitchen hatch. Every fortnight, a volunteer circulates selling raffle tickets which members place beside their drinks. This is one way the charity raises funds. Prizes are donated, by members and volunteers, and tend to be sweets, biscuits, tinned food, cards or toiletries and are displayed on a trolley.

About ten minutes before the whole-group activity, the manager/assistant manager officially welcomes everyone, makes any announcements (e.g. upcoming events, deaths, birthdays – happy birthday is sung) and explains what the day's hour-long organised group activity will be. The hall has a built-in audio system. When the lapel microphone is used, members hear well, but it is often overlooked. The raffle is called before the group activity begins and winners choose their prizes; some go to the table and select, while volunteers take the display to the less mobile.

At lunch time, volunteers help attenders move across to the lunch tables. Once served by the cook and kitchen volunteers, two or three volunteers take lunch to the tables. After serving those with a preference for small portions, whole tables are served so that members may eat at the same time. Second helpings are offered when available. Volunteers circulate offering squash from jugs. Meals often generate conversation (e.g. watery custard, delicious cottage pie). Some have second helpings. Most volunteers sit separately to eat a packed lunch while one or two join the attenders. Once lunch has been eaten, the 'active member' who arrives early to help with room set-up stands and formally thanks the week's volunteer cooks for their delicious meal. All applaud, agreeing that it had been a lovely meal. Lunch is unrushed yet always finishes by 12.45pm. A volunteer, the same one each week, then circulates collecting money for lunch and transport, where applicable, and logs payments. An 'active member' helps the volunteers to clear the tables, wipes tablecloths and folds them away with a volunteer. While attenders are eating, volunteers set up three folding trestle tables with chairs for the afternoon activities. Some attenders remain at the lunch tables chatting. Two or three join the short worship service in the adjoining church. The service is sometimes taken by the organisation's Chair who circulates afterwards and helps to serve mid-afternoon refreshments to members. The week's cooks and kitchen volunteers start

the washing up after which some stay and join in afternoon activities. The hatch is kept closed to minimise background noise.

In the afternoon, most attenders sit at the same table each week. One who has advanced dementia is unable to join the more interactive activities and colours pictures in a colouring book with felt tips alongside other members. Two or three attenders, who sit together in the morning and for lunch, sit apart by the stage. One cannot see to join in and prefers to knit or chat, another also knits or does crosswords and the third chats with the others. The 'conversation volunteer' joins in the card games, assisted by members, and chats with anyone passing by. Two of the men play cards every week, while the other sits by the stage to 'people-watch' and chat with volunteers. There is a low buzz of conversation throughout the afternoon. During the day, manager and/or other staff pop in regularly to ensure everything is going smoothly and ask if any problems need addressing.

Volunteer drivers tend to arrive early and sit and chat while waiting. Attenders start to get ready to leave when they see them. When attenders start to leave, a volunteer, a volunteer driver and the 'active member' store the chairs and tables on the stage.

A quarterly newsletter, printed courtesy of a local company, features a 'Member Interview' and a 'Volunteer Interview' which share facts that others may not have known (e.g. about their working life) and local news or information pieces (e.g. about Healthwatch, local fairs, services for carers, upcoming hearing aid battery changing sessions) as well as 'In Loving Memory' notifications of members/volunteers' deaths. Individually named copies are distributed at the centre. It is read out to the sight-impaired attender.

Observations on the building

Although in a shared building and with three doors, attenders do not get lost. However, at the end of the day, care has to be taken with one attender with dementia who tries to leave before the driver is ready. Despite being a high-ceilinged church hall, the room feels welcoming because of the chair layout and the detail with which the lunch tables are set. Occasionally, chairs suffering continence 'accidents' are placed aside to be cleaned by people who maintain the building.

5.5 Voluntary sector day centre 2 (DCV2)

5.5.1 Area profile

Location characteristics: Rural town with population of approximately 9,000, surrounded by villages, and an area of socio-economic extremes. DCV2 is located 400 metres from town centre.

Local authority population: Just over 100,000
19% aged ≥65 years
96% white
99% white among ≥65 group
(Office for National Statistics 2011)

5.5.2 The provider and premises

DCV2 is one of three day centres run by a local not-for-profit provider of services for older people that is affiliated to a national umbrella organisation. It operates in a 'community hub' building. Built in 2013 in conjunction with a new housing estate, as a planning permission linked developer contribution, this hub houses a variety of community facilities and organisations including a library, a church, a housing association, a Citizen's Advice Bureau (CAB), a young people's support and social organisation offering recreational activities and advice, a sensory room and a day centre for adults with learning disabilities in the room used by DCV2 on its non-operational days. It also hosts sessional activities such as blood donation sessions, a drop-in for people with acquired brain injury, a MIND drop-in for advice, assessments and training about mental health, NHS Health Trainer support with healthy eating, stress, wellbeing and managing smoking and alcohol intake and an outreach sexual health clinic. A young carers group and an active retired group meet there. Classes include pilates, yoga, Morris dancing, a singing group, sewing and activities for children (e.g. dance, drama, pre-school music and rhymes and sessions in the sensory room). The centre is also a local authority 'gateway' in which advisors can assist with, for example, financial and benefits advice, disability equipment information, Blue Badge applications (these allow disabled people certain parking freedoms) and death registration.

The day centre's double entrance doors are beside the centre's reception desk and lead off the library. It is a large, bright room with windows along one side. On the right, as one enters, is a two-seater sofa under a wall-mounted television screen beyond which is another table that displays the tombola and sweet shop in the morning. On the left is an accessible toilet, a cloakroom, where some attenders hang their coats (some put them on the armchair backs), the day centre manager's office (shared with the Building Manager), a second accessible toilet with an adult changing table, a shower and screen with a second door on the opposite side ('Jack and Jill' doors enable a room to be accessed from two directions) and a kitchen with a hatch through to the main area. The hatch door is kept open all day. Past the kitchen are a small meeting room, a

therapy room (with 'Jack and Jill doors'), a cupboard and, in one far corner, are double doors to a sensory room. Two large cupboards, containing tombola prizes and other paraphernalia, are on the far wall. In the far right-hand corner are double glass fire doors to the garden which leads to the car park.

Lunch is eaten at two six-seater tables near the entrance. At the far end, brightly-coloured (green, orange, purple) fabric-upholstered armchairs and two two-seater sofas are arranged in a small circle with small, folding wooden tables next to them. There are two gaps, one by the double fire exit doors next to chair where the wheelchair-using attender sits, and the other, opposite, which attenders walk through to sit down. This entrance is also used to place quiz scoreboards. Furniture is arranged by day centre staff each morning.

5.5.3 A description of the day centre

Box 7 provides an overview of DCV2's aims, users, capacity operational days, charging and funding, structure of the day, meals, transport, activities, staffing and links with community and voluntary organisations, health and social care. A narrative description of the day follows.

Box 7: Overview of DCV2

Aims
To provide the opportunity to meet new people, take part in a full range of recreational activities and receive a nutritional hot meal.
Target users, attenders and capacity (research day)
Socially isolated older people with transport needs. Personal care is not provided, only assistance (e.g. to get into shower or go to toilet).
Capacity: 25. Registered: 11 (14 on other operational day)
Attendance during fieldwork: 6-11 (21-25 reported at time of recruitment). Two people stopped attending during this period due to a move to a care home (n=1) and impaired sight and hearing which an attender felt reduced her enjoyment (n=1). Another's place was being held and she did not attend during the fieldwork period. A fourth began a long-term absence after breaking a hip at the end of the period. Six more attenders had left since the manager started in her role, 10 months previous to fieldwork, due to death (n=1), moving into care homes (n=3), moving to mental health services (n=1) and moving areas (n=1).
Centre records showed that the 11 registered attenders were aged 76-94 years (average 85.9) and had been attending between 1.5 and 8 years. Eight lived alone, seven did not have a family carer and seven received no personal care service at home. None were carers. Four had self-referred while seven were family-referred. In total, 18 people attended across the two days.
On the last fieldwork day, the manager confirmed that four people on the waiting list of 14 were pending assessment. Of the other 10, one was attending for the first time on that day, two would start the following week, two had refused, three had started on the other day of operation but two had stopped - one had not liked it and the other's circumstances had changed – and two had started at the provider's other day centres. Attenders are referred to as clients.
Operation
Two weekdays. Closed between Christmas Day and 5 th January.
Charging and funding
Charge £10 per day, inclusive of lunch and refreshments and transport, increased to £12 during fieldwork. Toast 35p. Normally payable on the day, but monthly invoices in arrears are sent to those prefer this. All are self-funders.
Grant from local authority, rolled over for last three years after a three-year contract ended, for up to 15 per day. Income and expenditure is not separate for the three centres.
Raffle is a small fundraiser.

Structure of the research day	
10:00-15:00	Operational time (5 hours)
10:00-11:00	Arrival, refreshments/toast, lunch orders, sweet shop, tombola
11:00-12:00	Whole group activity (staff-led)
12:15-13:15	Lunch
13:30/14:00-14:45	Whole group activity (staff- or externally-led)
14:15-14:30	Refreshments (including biscuits or sweets)
14:45-15:00	Transport arrives and attenders are helped to get ready to leave
Meals	
Provided by local hospital. Minibus driver collects food in insulated boxes just before lunch time. Before serving, the manager tests food temperature and a staff member logs these. Lunch choices are delivered back to the hospital with the empty boxes. There are usually three main meal options (including one vegetarian) and salad selections and a choice of hot dessert, yoghurt, fruit or cheese and biscuits.	
Transport	
The provider's minibus is met by the manager, staff and volunteer in the morning and the provider-employed driver briefs staff on any matters arising on the journey. Currently using agency drivers as there is no permanent one. All but two attenders travel in together. These two use a local volunteer car scheme, booked by DCV2, arriving slightly after the minibus.	
Organised activities	
<p>No programme of activities is on display; these are noted in the centre's diary. During fieldwork, team quizzes, mainly using quiz books, were the usual morning group activity. Team names, chosen by teams, were usually topical and content varied (general knowledge, brain teasers, mental agility, reminiscence, science and nature and cryptic quizzes of names of sweets and local landmarks). Often these used half the time and the remainder was filled with one or two shorter activities of around 10-15 minutes. These included individual quizzes (e.g. name a place beginning with a letter selected from a tub of letters), group crosswords, charades, chair exercises, floor hoopla and poem readings. One week, places appearing in vintage local postcards were identified and discussed; another week attenders shared snippets of information about where they were born, had lived, their first job and the highlight of their lives.</p> <p>Afternoon activities led by visitors included a season-themed poetry reading and discussion, yoga, a consultation-talk by a NHS Community Health Trust representative about plans for new joint-use NHS buildings and a musical performance organised by the learning disability day centre for their clients. Where these did not last for a whole session, they were supplemented by internally-led quizzes (e.g. throwing an inflatable quiz ball, true or false cards), group crosswords, guessing the object in the bag, charades and I-spy. Staff and volunteer-led afternoon activities included card-making and musical bingo.</p> <p>During the period, there was a Bring and Buy Fundraising sale and two trips (fish and chips at the seaside and a boat trip).</p> <p>While the fieldwork day is usually quiz day, the programme on the other day of operation was very varied, often with outside speakers or entertainers. Recent activities included falls prevention exercise with a personal trainer, a talk by a Police Community Support Officer, a visit to one of the provider's other day centres, a singing performance and chocolate tasting. Occasionally, the sensory room is used.</p>	
Opportunities for involvement	
No structured opportunities were identified. One extraordinary meeting with the organisational manager took place during fieldwork. Otherwise, feedback appeared to be gathered informally.	
Staffing	
<p>One (acting team) manager, two care staff (one long-term agency) and one volunteer, with a second volunteering post advertised on the provider's website.</p> <p>Staff roles include washing up refreshment crockery and loading the dishwasher after lunch.</p> <p>DCV2's long-term manager had left 13 months prior to fieldwork commencing. The replacement, who started three months later, had failed the probationary period and a frontline care worker, also formerly the deputy manager, promoted, starting to operationally manage DCV2 and its workforce six months prior to fieldwork. From the perspective of the provider's manager, she was still in training, therefore had not yet been given budgetary control.</p>	
Links with the community and voluntary organisations	
<p>Monthly Hearing Aid Clinic run by a charitable organisation for the deaf and hard of hearing in the therapy room. Open to residents of the area, attended by up to around 20 and used by attenders.</p> <p>Occasionally, a jewellery-maker visits selling jewellery. A self-employed masseuse who takes attender and external bookings visits 6-weekly.</p> <p>Provider tries to link with schools (e.g. Duke of Edinburgh students), inviting pupils to speak with older people and find out about their lives thereby trying to break down ageist assumptions about older people.</p>	

Links with health and social care

Local volunteer car scheme, based at the hospital and usually for medical appointments only, provides transport for two attenders.

Chiropractic (self-employed) visits fortnightly (c.£19/session compared with £45 privately in town) on other operational day.

According to the provider's website, eye tests are also available at DCV2.

Referrals received from GPs and Health and Social Care Coordinators, employed by the local authority and the Clinical Commissioning Group and based at GP surgeries.

Local authority-employed Community Warden visits every few weeks to check if attenders have concerns needing to be addressed.

On the way in from the minibus, staff chat with attenders about how they are. Attenders then take their usual place in the circle of chairs and chat or browse the selection of magazines on the small tables. Some are set up with cushions and one with a footstool. Some bring in things to show each other. They are served tea/coffee which staff and the volunteer prepare to attenders' preferences by consulting the laminated list in the kitchen about milk and sugar, having first checked attenders' preferences. Toast is served on plates to those who would like it. One staff member usually jokes with an attender about having ensured they have buttered it right up to the edges as they like it. Some have biscuits, served from a plate.

There is plenty of time before the morning activity for chatting and there is much conversation and laughter. Even those who are deaf chat; one joked that she was her friend's eyes and her friend was her ears. During this time, the manager reads out menu options, notes lunch choices for the following week, and a staff member collects and logs attenders' money. Activity timings are quite flexible. These are sometimes interrupted if the manager has an announcement to make. They are also punctuated with banter with staff, particularly the manager. Staff and the volunteer make modifications to activities to include the attender with advanced dementia, give her props or sit beside her and explain what is happening.

During the activity, staff set tables with pale green tablecloths, a small vase of plastic flowers, salt, pepper, cutlery, white paper napkins and transparent plastic tumblers. The activity stops once lunch arrives to give attenders time to use the toilet before lunch. Lunch is leisurely. Some attenders sit with different people to the ones they have been beside in the circle. The volunteer offers squash and water from jugs while the manager and one staff member serve meals while another distributes them. Individual food preferences are known and catered for, and the severely sight-impaired attender is supported to know what is on her plate and where. Staff and the volunteer take their own lunch, sitting and eating with attenders if there is space, once all have their main course. Attenders are offered second helpings and the plates of those who have finished collected before dessert is served. Once attenders have finished eating and plates are collected, staff remove tablecloths which the manager takes home to wash and iron. Attenders often stay at the table chatting until 1.30pm. Two attenders regularly go to the library after lunch

to borrow and return books. Staff had made appointments for one attender to visit the CAB several times during fieldwork. After lunch, staff take the wheelchair-using attender outside so that he may smoke a cigarette. The manager eats lunch after crockery and cutlery have been cleared, the dishwasher loaded and everyone is seated in the circle.

The hatch and door to the kitchen remain open all day so conversation noise sometimes makes it difficult for attenders to hear the afternoon activity.

At the end of the day, one person remains in the room to ensure the money is secure while the manager, other staff and volunteer accompany attenders to the minibus, help them in. They then stand in a line and wave as the minibus leaves, and the attenders wave back and some blow kisses.

A staff member is trained to file and polish nails (charged at £2.50) on request and, as a hairdresser, also gives haircuts for a donation to the centre (usually £5). Attenders may also have a shower which happened very rarely, according to the manager.

Observations on the building

The room used was a bright, colourful and welcoming room overlooking the garden. Having a library and CAB on site was useful for attenders. During fieldwork, attenders were invited to join the learning disability centre's barbeque and entertainment in the garden. However, people constantly came in and out to use the kitchen and fetch items from the small meeting room. A learning disability centre attender was well-known as she often visited to take magazines and needed to be guided back to her own room. Workmen repaired the fire doors and fixed a television to the wall during activities, which was disruptive, and having the doors open made the room cold. In the mornings, there was also background noise from the children using the sensory room and the baby and toddler groups in the library. During fieldwork, the manager introduced provider-branded t-shirts for security but only the volunteer wore these; others found them uncomfortable. Despite the accessible toilet and therapy room having 'Jack and Jill' doors, no attenders got lost, although staff needed to keep an eye on the attender with more advanced dementia. An extra staff member had been employed when the centre moved to this location because of its numerous access points. At a follow-up visit ten months after fieldwork, I noticed that card-operated entry and exit had been installed. Prior to fieldwork, the provider's manager had also indicated the problematic nature of the fabric chairs with respect to continence 'accidents'. Some of the two-seater sofas were very low. While these were not currently needed, increased numbers would mean attenders would need to use them and would have difficulty getting up.

5.6 Summary

Centres' differences extended to their providers, premises, operational days and hours, access arrangements, attendance numbers, funding and charges, activities, staffing, meal provision, links with the voluntary and community sector, social care and the NHS. All centres aimed to improve their attenders' quality of life by focusing on their mental and physical wellbeing, mainly by making available social opportunities and a range of activities. Two also aimed to offer nutritious meals and physical rehabilitation, two aimed to provide information and advice and one aimed to support family carers and be a resource for the local community. Two set their overall aims within a framework of enabling attenders to remain at home. Subjectively, day centres all had a welcoming atmosphere.

By describing the day centre case studies in detail, this chapter has set the scene for the next four chapters, which cover centre managers' and local authority employees' views on day centres, motivations for centre attendance, attender characteristics, the use of validated scales and outcomes for attenders, family carers, day centre volunteers and staff.

Chapter 6 Day centre managers' and local authority employees' views of day centres' role and purpose

This chapter builds on the day centre case studies in the previous chapter by setting out the views of centre managers and local authority commissioners and signposters/referrers (defined in 1.5.5). It addresses the following two research questions for this study:

4. How do potential commissioners and referrers/signposters perceive day centres and why?
5. What service do managers, trustees and owners believe their day centre offers, how do they view its place within the market of social care provision and its relationships with local community and health services, and what are their plans for the future?

After summarising the approach taken to data collection, participant characteristics are outlined. Next, managers' and local authority participants' views on the Unique Selling Propositions (USPs) and any 'Added Value' they perceive these centres to offer are summarised. These terms are defined in Section 6.3. This chapter then sets out local authority employees' views on day centres' relevance to policy, their role and purpose and what potential outcomes their managers believed they offered. It then reports these participants' views on centres' current and potential role within the social care and health systems, including what managers perceive their day centres currently offer, notable changes over recent years, plans for the future, the need for change and what centres' may have the potential to offer in the future. These views are contextualised by participants' views on relationships with the NHS and the importance of evidence. Finally, the chapter is summarised.

Verbatim quotations from participants are used in Chapters 6-9 in the reporting of findings and to illustrate points being made. Emboldened text in these indicates emphasis in the original.

6.1 Approach to data collection

Data were gathered qualitatively in interviews. Local authority participant interviews lasted, on average, 62 minutes (range 40-90 minutes); one interview was with two participants. Manager interviews lasted, on average, 95 minutes (range 59-160 minutes).

After establishing whether local authority participants were familiar with participating day centres, they were asked to explain their current and previous roles.

Commissioners and signposters/referrers were asked about their personal opinions on the role and purpose of day centres for older people with low, or no, cognitive impairment and whether they considered such day centre services to be relevant to social care policy and local commissioning targets. This conversation also covered who they thought did or did not attend day centres, and why. Participants' views on what day centres offered, or had the potential to offer, the health and social care market were then gathered, and commissioners were asked whether day centres could collect any data about attenders that may be helpful when making commissioning decisions.

Managers were asked what potential outcomes they considered their centres offered, how they thought centres currently fitted into the market of social care service provision and about centres' relationships with local services. After exploring whether any significant changes had been experienced over the previous five years, managers' plans and expectations for the future were discussed.

As 'vendors' or providers operationally responsible for day centres, managers were asked for their views on their own centre's USP and 'Added Value'. Local authority employees, as potential purchasers or 'users' (in that they may have commissioned services to meet their own targets and in that having a service to refer to enabled them to do their job, for example), were asked the same question. Starting with the specific and moving onto the more general, responses concerning these are covered first in this chapter, after the following participant overview.

6.2 Overview of managers and local authority employee participants

6.2.1 Managers

Manager participants (n=6) were a mix of day centre and provider organisation managers. One managed the provider organisation while two managed both the provider and the day centre. Three were centre managers, one of whom was on a year's secondment with the same provider. Their time in role varied from nine months to 32 years (9 and 10 months and 2, 15, 21 and 32 years). Prior social care roles included being a day centre's business director, working as a care worker and acting manager in the same centre, managing a dementia outreach team, being a care worker with young disabled people and people with HIV, and managing a housing scheme. Prior roles outside social care included auditing, selling advertising space and NHS administration.

6.2.2 Local authority employees

The sample consisted of 13 local authority employees who commissioned services (n=5) or who may have signposted or referred to day centres, or other services, during their work with individuals (n=8).

Commissioners' roles included Coordinator, Commissioning Manager, Strategic Commissioner, Joint Commissioning Lead and Area Director. Two had been in their roles for four years and the others for one, five and ten years. Three were responsible for older people's services; two commissioned a broad range of services and one commissioned leisure, health and wellbeing services funded by the Better Care Fund (a budget pooling programme that aims to encourage joined-up NHS and care services). Two commissioned across client groups; one was responsible for wellbeing services (older people, dementia, physical and learning disability) and the other for complex care services (excluding dementia and other mental health conditions) and the quality control of these. One had additional responsibility for developer contributions (planning permission for new constructions may require developers to contribute to the local infrastructure). One was also responsible for Continuing Healthcare (NHS payment for some health care needs) and was the lead for learning disability, transport and care. Previous roles, all within the same authorities, included managing a service operational team, Commissioning Officer, commissioning services for people with learning disabilities, managing and developing leisure provision and reviewing services as an Efficiency Manager.

Signposter/referrer roles spanned people's contact with social services, from initial access to agreeing on care and support packages and reviewing care. The sample included an Access and Support Officer who did duty work as a first point of access and did screening, assessment and signposting work with allocated people. The two Case Officers managed the assessments, care and reviews of their caseloads of clients. The Support Planner arranged individual support. One Social Worker worked with adults of all ages with complex and longer term needs, and the other did not specify a client group. The Care Manager worked with all adults doing assessments, reviews and safeguarding investigations. The final participant led on Special Projects and, in her role of Service Manager, scrutinised and authorised care and support plans. Three had been in post for a year or less, one for 18 months, two for two years and two for seven years. Prior social care roles included running classes for younger disabled people and people with learning disabilities in a day centre, mental health outreach, social work, management, assistant director for adult services in different local authorities. One had been the assistant manager of a voluntary-run dementia day centre. Former roles outside social care were recruitment and two project roles in charities.

6.3 Unique selling proposition of and added value offered by case study day centres

The Unique Selling Proposition (USP) is a marketing concept referring to *'the one feature of the product that most stands out as different from the competition, and is usually a feature that conveys unique benefits to the consumer'* (Blythe 2005:250). Added Value helps people make choices about what to purchase (Sheth *et al.* 1991). It is multidimensional but lacks an agreed marketing definition (de Chernatony *et al.* 2000) but is dictionary-defined as *'an element added to a product that makes it more attractive to customers'* (Collins 2017). Since social care services are now part of a 'market' of services, day centres are 'products' to be advertised, sold and purchased.

A few participants were unfamiliar with the terms 'USP' and 'Added Value'. As potential purchasing and referring 'customers' of the case study day centre in their area, local authority employees were asked their views on its USP and 'Added Value'. Reflecting their roles, location or the specific area they worked in, not all commissioners or signposters/referrers knew the case study day centre. Four commissioners and three signposters/referrers felt sufficiently familiar with it to give their views on its USP or added value.

Most participants took a consumer (end user) perspective in describing these. Participants' views of case study day centres' USPs and any added value they offered related to facilities available in and the location of the buildings themselves, including other on-site opportunities, other services available from providers, the atmosphere, aspects of the service provided and benefits experienced by volunteers (see Table 9).

Only one participant perceived a case study day centre as having no USP and no added value. According to its commissioner, DCHA had no USP. Although currently offering no added value, it was seen to have potential, having been hindered by the integration of management with that of extra care services after the manager's secondment. This was felt to be a retrograde step since she was considered to have been a creative manager who gave thought to the needs of non-resident attenders. However, the commissioner considered the day centre itself to be the added value offered by the extra care facility where it was located.

Table 9: Managers' (MA), commissioners' (CO) and signposters'/referrers' (SR) views of USPs and Added Value

DCHA	
USP	<ul style="list-style-type: none"> Brightness and aspect to enclosed, safe garden accessible directly from the centre (MA). High quality of staffing (MA). Restaurant instead of meals on wheels (SR). Residents can attend meaning the group is very mixed (SR). Welcoming and friendly - not the case for all day centres (SR).
Added Value	<ul style="list-style-type: none"> Programme included purposeful and fun activities (e.g. poetry reading, basketball, baking, arts, current affairs discussions, reminiscence and entertainment) (MA). Availability of guest room for any attender experiencing serious problems at home (MA). Attended by a small number meaning <i>'everyone feels the need to be with each other'</i> (Signposter/referrer3) - not the case in larger centres. (SR)
DCLA	
USP	<ul style="list-style-type: none"> Stroke survivors group run by its own trained staff. It offered more varied activities than other providers' groups and was one of the few for older people (MA) Large building offered potential to <i>'develop a wide variety of activities there'</i> (Commissioner2). Opposite a park which could be used for outdoor activities⁷ (CO). Consistent management between this and another day centre (CO).
Added Value	<ul style="list-style-type: none"> Warm and welcoming, yet professional, environment with staff who were <i>'always prepared to go the extra mile'</i> (Manager2) (e.g. by acting on needs instead of referring on). The Stroke Club as this drew in the community (CO). High meal quality (CO).
DCV1	
USP	<ul style="list-style-type: none"> Operation on day of the host church's mid-week service enabled attenders to worship (MA). <i>'Its personalised, individual approach (...) in a very caring and supportive environment'</i> (Commissioner4) meant attenders were welcomed, looked after and felt as if they belonged. This was said to be <i>'down to the staff and the set-up of [provider], I think, in terms of that ethos they have and the brand (...) without that, it wouldn't be as good as it is, I don't think'</i> (Commissioner4).
Added Value	<ul style="list-style-type: none"> Each attender was known as an individual (MA). Benefits experienced by its volunteers (MA). (Chapter 9 covers these.) The contribution of a blind and physically disabled volunteer was described as a <i>'good tonic'</i> (Manager1) for attenders because of her constant cheerfulness despite her disabilities which was thought to give some perspective on attenders' own situations (MA). Other support, such as holidays, that its provider offered meaning <i>'it's not just they go to a club one day a week and go home again'</i> (Commissioner4).
DCV2	
USP	<ul style="list-style-type: none"> High number of day trips undertaken, made possible due to its small size (MA). It was the only service specifically for older people in its area, which was rural, meaning that residents wishing to attend a day centre did not have to travel to the nearest bigger towns 10 and 12 miles away (MA & SR).
USP & Added Value	<ul style="list-style-type: none"> CO (USP) & SR (added value): Being in a community building contributed to normalising day centres and meant the centre was easily accessible for enquiries and less daunting to go into since it was just another door in a familiar building: <i>'I think that the more people start to think of day centres as buildings that they can just walk into and get access to a range of different things and not just about a building that you are transported to and you play bingo in is going to be better. (...) you go in there and you can go to the café and you can go to the library and it does a whole load of things. There are other organisations in there as well'</i> (Commissioner3).
Added Value	<ul style="list-style-type: none"> Its location in a busy community hub building meant it was integrated into the community with ready access to other services (e.g. Citizens Advice Bureau, library) and facilities (e.g. sensory room). The hub manager also alerted the centre to any activities and events potentially of interest to attenders. This was a very different experience to its former location, in a leisure centre, where the centre was excluded from events (MA). That the provider offered other services provided further added value (MA). As a satellite centre, away from the provider's main location, it was an outreach service connected with the provider and the other services it offered (CO).

⁷ The commissioner may have been unaware of the centre's own large and accessible garden.

6.4 Day centres' role, purpose and relevance to policy and targets

There was some mismatch between day centres' roles and purposes described by local authority participants and their views of centres' policy-relevance which, in most cases, was more evident among commissioners (see Table 10). Overall, a greater proportion of signposters/referrers than commissioners viewed centres as having roles and purposes relevant to policy. However, commissioners considered that day centres have a place within care and support and, in three case study areas, contributed to local commissioning targets. In the fourth area, centres for people with dementia were perceived to be meeting commissioning targets more than the current model of generalist centres, a view that was said to drive a current initiative to co-produce a new strategy for day opportunities that included day centres and non-building-based opportunities.

Table 10: Commissioners' and signposters/referrers' views on the role and purpose of day centres and their social care policy relevance

Views on day centres	Number viewing day centres as relevant to each policy theme						
	Preventing / delaying deterioration	Promoting wellbeing	Information & advice provision	Supporting carers	Supporting people to remain at home	Personalisation	Partnership working
Commissioners (n=5)							
Role & purpose	5	5	3	2	1	2	1
Relevant to policy	2	2	2	1	2	2	1
Signposters/referrers (n=8)							
Role & purpose	5	8	4	5	1	5	-
Relevant to policy	6	6	3	5	3	5	-

Seven of the eight signposters/referrers highlighted the importance of day centres, first, as a support option to signpost or refer to and, second, as a resource and a place to go for individuals and family carers. Other individual support options, perhaps purchased with direct payments, while good for some, were felt not to suit everybody, something also the case for day centres.

Unaware of any research evidence about day centres, signposters/referrers said their views had been influenced by having worked in or visited them, positive testimonials, from social work training and a day service review or closure two were involved with which had improved one's understanding of them to the point that she had positively changed her referring behaviour. Information about services was shared informally by email or in person or at team meetings to which service providers were sometimes invited; one authority had just started a newsletter.

Managers believed their day centres provided benefits to older attenders and family carers as well as to those volunteering in and staffing them.

Table 11 summarises managers' and local authority employees' perceptions of day centres' outcomes, role and purpose within the Care Act 2014 themes. There was consensus among the three groups that day centres promoted wellbeing for their attenders and family carers, prevented or delayed deterioration, and provided information. They were said to relieve isolation, provide activities and a change of environment by getting people out of the house. They were perceived to improve mental wellbeing, or delay its decline, by giving a sense of purpose and structure, promoting feelings of independence, being somewhere comfortable and emotionally safe in which to gain a perspective of one's own situation and in which there were trusting relationships with staff who knew attenders' needs. Staff monitored attenders' health and wellbeing, including safeguarding concerns, thus promoting mental and physical wellbeing and preventing or delaying deterioration. Physical activities, a warm, accessible and safe environment and, if appropriate, personal care contributed to the prevention or delay of deterioration. Centres were likened to a first point of access for other services in that they provided both practical and informational support, particularly important for those with limited reading abilities and those whose partners had dealt with paperwork. Attenders used other services in centres and were connected with other providers' or their centre providers' services (e.g. shopping, chiropody, hairdressing, bathing). Talks concerned physical health or safety (e.g. nutrition, managing skin conditions, foot care). Practical support included planning appointments (e.g. wheelchair service, speech therapy), some took place at a centre on an attendance day which negated the need for a potentially problematic home visit. These functions were also relevant to the theme of partnership working.

Half or fewer participants in each group perceived centres' role as supporting people to remain at home. One commissioner who did so talked about centres keeping people out of residential care or hospital and linked this with promoting wellbeing. Neither commissioner considering centres relevant to this theme viewed them as preventing or delaying deterioration. One signposter/referrer linked their preventive role with keeping attenders independent and another with preventing a move to residential care by supporting carers.

There was also consensus that centres supported carers of attenders and, to a limited extent, provided them with information. One commissioner, though, considered that day centres were to address older people's, not carers', needs.

Table 11: Perceptions of outcomes of individual involvement with day centres in the context of their role and purpose and policy relevance

Care Act policy theme	Managers' perceptions (n=6)	Commissioners' perceptions (n=5)	Signposters/referrers' perceptions (n=8)
Promoting wellbeing: - reduces social isolation	For attenders		
	6	4	6
- activities / time occupation	Supported activities are something different and sociable to do and the opportunity to try something new (4)	2	5
- gets people out house / place to go	3	3	2
- a nutritious meal	2	2	3
Promoting wellbeing Prevent/delay deterioration Personalisation	Improve mental wellbeing, or a delay in its decline (5): - leads to feeling comfortable and safe, having something to look forward to and to feel part of, gaining perspective on one's situation through group support and benefits of companionship and enjoyment - supportive environment and trusting relationships with staff who know them and understand their needs.	Gives a sense of purpose (2)	Gives a sense of purpose and something to look forward to and adds structure to a week (4) Is a 'safe' place in which to belong and share concerns (3) Promotes feelings of independence due to time away from family (1)
Promoting wellbeing Prevent/delay deterioration - physical wellbeing - physical safety - safeguarding	Potentially play a role in physical wellbeing & health by (5): - providing physical activities (1) - prevent decline or crisis by monitoring wellbeing, health and safeguarding concerns (3) Accessible environment (1) Personal care – if in a suitably-equipped centre (1)	Undertakes health and wellbeing monitoring 3 4	
		Physical safety (1) Physical activity (1)	Warm place in which people are looked after (2)
Information and advice: - practical support - information - access to other services Partnership working	Connects people with other information or other support services (n=2) via visiting speakers or signposting.	Information on own and community activities and connects people with other services (3)	Practical support and information (5): - form filling, visiting speakers, referring or signposting, location for other services
Support to remain at home	Promotes independence and supports people to remain at home (especially if without a care package) (3)	Supports people to remain at home 2 1	
Supporting carers Information and advice	For family carers		
	Provides a break while feeling reassured that family member is comfortable and safe (3). Information and advice (1).	2	5
Promoting wellbeing	For day centre volunteers		
	Feeling better, improved confidence and self-esteem due to feeling needed (4). Improved social skills (1).		
	For day centre staff		
	Job satisfaction (4): feel they make a difference, and they enjoy caring for and helping people. Grow in confidence and knowledge (1). Help launch a career in social care or health (1).		

Certain participant views about centres' relevance to personalisation do not appear in Table 11 as they concerned service delivery rather than outcomes. Signposters/referrers were much more positive than commissioners about this. The former spoke about having a choice of centres or other services, choices of activities - which change with changing clientele - and knowing individuals' support needs. A commissioner perceived that monitoring health and wellbeing equated to a highly personalised service in which relationships had been built, thus linking personalisation with preventing or delaying deterioration. Another commissioner was sceptical about the extent to which personalised services could be offered because attenders were *'not known to the system for very long. By the time you kind of develop a really good personalised offer, that person has deteriorated or gone to live in a care home or whatever'* (Commissioner5). According to her, delivering a range of appropriate activity choices was complicated by the centres' congregate nature. Her comments concerned lack of choice of, and flexibility between, days and times, inability to opt to do something different instead occasionally, meal options, preferred staff, forms of address and information given to families. An additional challenge to maintain a personalised approach was the need to remember to keep asking attenders about their preferences.

6.5 Current commissioning and signposting/referring practices and the use of day centres

Reported reasons for commissioning day centres were policy-related. They included reducing isolation, providing opportunities, supporting carers, supporting people to live at home (also phrased as reducing the need for institutional care), for prevention and partnership working. Authorities differed considerably in their service provision and their approaches to funding centres, but specialised and general older people's centres were funded in all four. In two areas, commissioners reported grant funding centres; one had moved from block contracts to spot contracts; lengthy block contracts in the fourth were due to end shortly, but no information about plans was provided. One had decommissioned day centres in care homes due to lack of demand. Contracts or commissioned places did not include transport.

Referrals or signposting to day centres was mainly due to a wish to reduce social isolation, often related to mobility restrictions or dementia, and for carer respite. Some older people referred to day centres had personal care needs, but not beyond what could be managed at centres. For others, getting out was problematic thus other community options were unsuitable. For one, a reason for referral might also be for a more thorough needs assessment to be undertaken by the centre. Most said a referral would be made if people wanted to try a day centre, although other options would usually also be explored that may meet their agreed outcomes.

In one area, signposters/referrers had been temporarily discouraged from making referrals during a period of change. Two observed that, in the past, day centres' preventive role had been 'upstream' whereas people currently had to have needs before attending one.

Types of centre referred or signposted to depended on older people's choices and included all kinds of building-based centres: unstructured community centres with drop-in activities, structured (all-day) centres run by the local authority or voluntary sector, those for specialised user groups (e.g. ethnic group, dementia, brain injury, learning disability) or in which attenders were mixed. Mobility needs were said to play a role in people's choices. Community centres providing drop-in activities offered variety and tended to be cheaper. However, they did not provide transport so *'you would have to get taxi cabs and that is unsustainable in the long term because you only get a certain amount of discounts on that. And so, sometimes, sometimes, the structured day centres can be enticing because they offer transportation'* (Signposter/referrer1).

Day centre use, broadly, was felt, by some commissioners and signposters/referrers, to be needs-driven. Some noted that need might have prompted action rather than an active choice to attend a day centre. A choice to attend was linked with previous active citizenship or socialising, a specific event held, personal recommendation, being female or of an older age, and clarity of explanation concerning what a day centre was. A choice not to attend was linked with being mobile, feeling frail or unsociable, being put off by the term 'day centre' or having negative preconceptions of these. Those attaching stigma to centres or social services were thought to be of varying ages. Connotations of dependency, old age, need or illness meant centres felt irrelevant for some people. Various negative perceptions of centre attenders and activities had been heard. A few believed that these were not held by younger older people or younger adults with long-term conditions. Although renaming centres may combat such views, one commissioner commented that 'community centres' are different in that they hosted activities for various age groups including some specifically for older people. She considered that terminology was of no consequence; what mattered most was clarity that *'other people were also going to the same place for the same reasons'* (Commissioner5). For two commissioners, there was no stereotypical attender, rather knowledge and ability to find information (which advantaged higher income families) and the way a day centre was presented affected decisions. If presented as one of several options, people may choose to attend; if a response to need, people may not. Cost was also said to influence as did individual preferences and characteristics.

6.6 Day centres and their potential within the social care and health system

This section details the views of managers, commissioners and signposters/referrers about day centres and their potential within the social care and health system. Managers' views on what their centres currently offer to the system and any notable changes experienced over the previous five years are reported first. Next, current plans and the need for change are then outlined. After setting out aspirations and views of potential for the future, this section ends with views on relationships with the NHS and the importance of evidence.

6.6.1 Managers' views of what day centres offer the social care and health system

Managers believed centres worked in partnership with local authority signposters/referrers, giving them somewhere to refer people to and signposting back as necessary. Centres were felt to be a gateway to services to which signposters/referrers may not have had access, such as providers' services or services taking place in centres (e.g. chiropody, advice). High social worker turnover negatively affected relationships but also enabled opportunities to speak to new staff at team meetings, reinforcing knowledge about providers which signposters/referrers could then disseminate. They also considered that centres supported NHS professionals who referred people to social workers for assessment or who visited centres for patient appointments, particularly district or community nurses who had high caseloads.

6.6.2 Manager-reported notable changes in day centre attenders and funding over the previous five years

Attenders

Changes in user characteristics and falling attendance had been experienced in all four centres. Physical frailty and cognitive impairments were now more severe, attenders were older, and proportions of cognitively impaired attenders had increased. Three managers said this was the case for newcomers while one attributed it to natural ageing while attending the centre. All centres were less well-attended. Daily places covered by one centre's block contract had been reduced by ten places three years ago. When recruited to this study, it was expecting an influx of around ten from another centre, but this was not apparent at fieldwork. Urgent requests for short-term places in another centre had reduced. Whereas empty places had always been quickly filled, this was no longer the case. However, waiting lists for both voluntary centres had built up due to work overload. One manager noted that attenders starting now would probably not stay beyond five

years and commented that the centre's role had evolved to include more complex physical care that needed equipment and expertise:

*'I think we've gone from being a day centre that did provide a hot meal, a chat and a few activities to actually providing quite a lot of **care**, which is probably why I talk about it as day care. You have home care. And I think this is day care. I don't think it matters whether it's a centre for older people or LD [learning disability] or dementia, complex needs, whatever it is, it's day **care** (...) show me a voluntary sector day centre where they have a hoist and a bedroom and two people doing 'PEG' feeding or bathing or two-person hoist.'* (Manager2). As stated at the start of this chapter, emboldened text indicates emphasis in the original.

Managers linked these changes with higher thresholds or eligibility criteria, moving from being open access to mainly referrals only, changes to charging processes, informal social services guidance discouraging referrals and the introduction of a requirement for older people's social work team referrals to be approved by a panel of managers for funding. This was said not to be the case for Mental Health Teams, and referrals of people in their 60s were increasing. Although numbers were still low in one centre, referrals were newly being received from recently appointed Health and Social Care Coordinators, who were NHS Clinical Commissioning Group-employed staff based in GP surgeries.

On a different note, one manager had noticed a change in attenders' attitudes; they were less reserved than they used to be and were *'more open at doing things and having a giggle'* (Manager3), meaning the atmosphere at the centre felt more *'upbeat'*.

Funding

While the overall sustainability and viability of the four centres were not adversely affected by funding changes, some change was reported by three centres. Levels of funding had reduced in two of them. At one, this had started five years previously, and the manager had now been informed of a further requirement to make 20 per cent savings over the next two years. Care staff would remain unaffected, but kitchen staff would be reduced affecting meal provision. At the second, funding had already decreased to 75 per cent of the full formula-based cost agreed with social services with a further cut of 1.5 per cent being made the year before fieldwork; funding and charges just offset costs. The level of service had remained similar, but externally-led activities and speakers had been cut down as the reduced funding also needed to cover the additional staff member required by moving to a shared building.

Voluntary sector managers emphasised the considerable time, effort and skills needed for acquiring funding which had increased hugely over the previous five years. There were longer application forms, more requirements to fulfil and the process was sometimes coordinated by organisations sub-contracted by funders. Heightened competition demanded knowledge of one's USP. The process was challenging for a manager with expertise in service provision not grant

application terminology. One preferred to constantly engage with, and remain visible to, potential funders by obtaining small grants from different sources rather than applying for large sums to be released over several years and which demanded frequent and in-depth monitoring. Summing up the current funding situation, she explained the importance of visibility and constant reminders:

'It's a little bit wobbly, but I'm confident. (...) you can never go on just your reputation, because some people might have been new to the post and they don't know about your reputation (...) I'm never ever surprised people not knowing about us, even though we've had a presence here (...) somebody comes up and says, "I didn't know you were here" (...) You can't be complacent about anything.'
(Manager1)

Finally, one manager noted that levels of funding per place taken up by people with dementia or learning disabilities were increased for voluntary sector providers whereas these were static for her more generalist centre.

6.6.3 Changes and the need to evolve

Commissioners in all areas reported changes in the commissioning of day centres. While all were at different stages, this transition had already affected or would affect centre provision. One authority had just tendered out (invited providers to submit bids to operate) previously local authority-run centres. Another was starting a review prompted by decreased demand. Another was focusing on internal processes before reviewing community services. In the fourth, there was a leaning towards shorter (fewer hours), individualised opportunities in community buildings.

Managers also reported plans were afoot in three of the four areas. These included a local authority review of day centre provision, a planned service restructure due to an expected move to outcomes rather than services-based commissioning and involvement in an internal project that aimed to expand and update the provider's range of services. In the fourth, the manager was waiting to hear the terms of a potential new contract.

Most managers recognised the need for day centres to evolve to survive. While some evolution was continuous and low-level, now was a time requiring active change. One view was that:

'Commissioning day centres seems to be out of fashion at the moment, with the perception that we will not need building-based services in the future and, in fact, several [councils] have already closed their day centres for older people. I believe that, for some older people in our communities, there will always be a need for a building-based service that can care for and support the most vulnerable in society.'
(Manager2)

All commissioners and signposters/referrers asserted a view that there was considerable potential for centres to offer more to the NHS. Commissioners felt certain barriers needed to be overcome first. These were the dominating delayed hospital discharge agenda, spanning Clinical Commissioning Group (CCG) areas and lacking sound evidence about any health outcomes gained from day centre attendance that CCGs needed for investment decisions. Since preventive work

undertaken in centres (e.g. social interaction, toenail clipping) did not offer immediate benefits, and evidence would be hypothetical, centres were '*a hard sell to health (...) it's difficult to get health to buy into that to the degree where they are willing to fund it*' (Commissioner3).

6.6.4 The future: aspirations, potential and the need for further change

In thinking about the future, managers were focused on survival, increasing attendance, supporting attenders and demonstrating impact. One aspiration was to attract younger older people as well as continuing to ensure the current, older clientele's preferences were met. One manager mused on the difficulties of doing this when many of the current group had memory problems. Marketing to individuals and social care teams would need improvement. While two managers planned to concentrate on behind-the-scenes quality, bring in more external specialists (e.g. art therapy, Pilates) and support staff morale by ensuring they had sight of positive feedback, two had ideas for the diversification and innovation they considered necessary for survival. Collaborating with other providers or merging centres potentially offered financial savings and a chance to enrich services. One manager believed the service could diversify, with extra staffing, to offer outreach and a signposting service for those not wanting a group service, with the hope that people may return when they needed assistance. One provider reportedly had plans to increase attendance by opening to private payers. Another aspirational solution was thought to lie in a new 'healthy living centre' style multi-purpose building, in which a range of rooms and facilities were available, in which to operate exercise, health screening, adult education as well as a day centre; this model would involve partnership working.

In thinking about what day centres offered, or had the potential to offer, the health and social care market, local authority employees were of one mind in suggesting they might be convenient locations for health outreach clinics or information sessions. Such developments would '*use the space as effectively as possible*' (Commissioner2) and be easily accessible to the wider community. Furthermore, consulting about health in a safe environment may be easier for older people. However, a longer operational day may be needed. A few signposters/referrers also raised the potential for offering short or long term rehabilitation or reablement such as mobility rehabilitation led by health professionals (e.g. walking, chair or stretching exercises), delivery of training by NHS staff to centre staff, community health staff and informal carers or developing links with hospital medical registrars. Local community health providers in one area were said to be positive about reaching '*a captive audience in one fell swoop, so it's efficient*' (Commissioner1), but investment was not forthcoming, even in more integrated local authority areas:

'we're quite an integrated council and health economy here, so lots of people know lots of other people, but when it comes to it, nobody wants to actually pay the money to hire the space.' (Commissioner5)

Only two commissioners and two signposters/referrers spoke about what day centres could offer other parts of social care. They suggested weekly social worker sessions for the wider community, improving carer support by opening over weekends, enabling direct referral into certain services (e.g. toenail cutting, bathing, handyman) and to safeguarding teams which might reduce Duty Social Work Team burnout, and undertaking assessments there, such as for bathing or Blue Badges.

Commissioners felt that integrating care in centres may require a different model of day centre or buildings with co-located services transforming them into 'one stop shops' or community hubs. Visions differed, covering different types of services and service providing organisations, social services, a health centre in which GPs, district nurses, occupational therapists and physiotherapists were based, or a library, which was a community building that has faced financial challenges. Commissioning day centres for wellbeing or information and advice, rather than to 'keep people safe' as presently, might draw in the local community, particularly people with lower needs, more than a traditional model. Any such strategic change or vision should be older people-led.

6.6.5 Relationships with community, primary and secondary health

The extent of centres' relationships with NHS services and professionals varied (see overview tables in Chapter 5). There was recognition across the three participant groups that relationships would need work since these tended to be with frontline individuals rather than organisations and had to be re-built when people left. They also agreed that connections with GPs could be improved. Managers reported that engaging with GPs was problematic as practice managers 'gatekept'; one manager had been unsuccessful in securing speakers for contractually-required health talks. Good relationships with one practice – and which tended to be with older GPs - did not mean these were replicable elsewhere, and GPs rarely made referrals to centres. A commissioner explained how the success of a social prescription pilot had been compromised by individual GPs' lack of knowledge, despite having potential to increase referrals and signposting to centres and reduce repeat GP presenters. Conversely, GPs were referring to a surgery-based wellbeing advisor who undertook assessments and signposted to services. Commissioners noted how difficult it was for voluntary sector providers to identify a contact person in NHS organisations. Similarly, CCGs may value the voluntary sector '*but don't really understand how to make links into it and how to kind of use it effectively*' (Commissioner3). According to one manager, good planning and being selective had been behind health-related initiatives becoming regular fixtures. Another found that CCGs seldom looked to the voluntary sector for solutions, and partnership working was hampered by fragmentation and poor internal communication within the NHS itself.

Among local authority employees, there were mixed views about where responsibility lay for developing relationships between day centres and health and social care. The onus was said to be on those with existing connections, on the NHS, on centre managers, shared between the NHS, managers and social care, or by older people on strategic boards. Joint commissioning and carrying joint assessments were felt to be important, partly because joint working improves understanding of needs and encourages further joint working.

6.6.6 Impact and evidence

Participant groups agreed that, in seeing people at centres, health professionals saved considerable time in arranging home visits, travel time to these and repeat appointments where access was not possible. It was also more convenient and, sometimes, safer for them. For individuals, it was also convenient and meant not missing a day, particularly important for single day attenders, and thought to be *'less stressful for all the people that have to sit at home waiting for the nurse'* (Signposter/referrer6).

Nonetheless, managers reported that impact was challenging to evidence and did not know where to find evidence of impact on either organisations or individuals. Scant evidence included one having received compliments, for example, from a Community Mental Health Trust consultant and two visiting student doctors having applied to volunteer. One centres' attenders were said to appreciate its diverse services. Managers were certain centres reduced the burden on the NHS, for example, due to people living alone improperly self-medicating or by centres undertaking foot care or detecting a urinary tract infection early which may reduce secondary care or pharmaceutical costs and reduce family carers' stress. Active relationships with health care providers were thought to protect older attenders from being overlooked or 'falling through' the gaps between services:

'When it's working well, it's brilliant, because it means that hopefully, nobody will slip through. There will always be somebody to signpost to.' (Manager1)

Thinking of the role of evidence, commissioners were asked if day centres could gather data that would aid commissioning decisions. They noted a need to be proportionate to ensure centres were not required to act beyond their capacity and that any data requested should have a clearly-defined purpose since *'the investment to do it to make it meaningful is probably not something we can afford in the current climate'* (Commissioner5).

Quantitative health outcomes data, such as longitudinal wellbeing data gathered using validated tools⁸ or numbers of GP visits, were preferable, for three, as they considered these had potential to influence CCGs' funding decisions, specifically concerning joint commissioning, while perhaps also

⁸ Outcomes Stars were mentioned. These measure change in pre-defined areas and are completed with a service user at regular intervals with the aim of individual progress. They measure whole service outcomes and benchmark against national averages.

being useful for Public Health and GPs. Two were happy with qualitative data collected by satisfaction surveys and contract monitoring visits which included provider and service user interviews. However, qualitative data might be more acceptable if presented using descriptive statistics.

Also of interest to two commissioners, due to the different staff skills felt to be needed, was a breakdown of what proportion of attenders' time was spent on activities, personal care and other support, as well as the most popular activities and activities attenders wanted.

To contextualise outcomes, two commissioners were interested in broader data about attenders (e.g. falls, family circumstances, health or frailty levels, other services received, activities attended and why they chose a day centre instead of other activities, e.g. bridge clubs, University of the Third Age). Two considered health or frailty data would be of more use to providers as it could provide an opportunity to add value to attenders' experiences, for example by undertaking falls prevention work with attenders if a health tool suggested falls risk.

In future, one commissioner suggested that data concerning effectiveness of any alternative model put in place might also be gathered, for example, use of drop-in sessions, community links or greater usership, whether new users' expectations were catered for and their demographics.

It was only after prompting that the above suggestions were made. The positive focus of the reasons for suggesting gathering health outcomes data contrast somewhat with the interest in how time was spent, which may infer possibilities for efficiencies based on these data. It is possible that commissioners may not have been accustomed to using data. Two did not use the local data already gathered; one pointed out that local authorities analysed domiciliary and residential care data but not day centre data, and another, in discussing data, realised that wellbeing and health data collected by its own Wellbeing Advisor were not used. Commissioners also reported that commissioning decisions were based on local priorities, policy-led targets or locally-gathered service use data (e.g. numbers of referrals), rather than on evidence of effectiveness.

6.7 Summary

Managers believed their centres offered preventive, wellbeing, practical and informational support for their attenders, wellbeing benefits and information for family carers and wellbeing benefits for centre volunteers and staff. They viewed their services as supportive to social care and health, although relationships with the NHS were hard to develop.

Although commissioners' and signposters/referrers' views of what centres offered mainly concurred with those of managers, commissioners were less aware of the relevance of these to

social care policy than were signposters/referrers, despite commissioning for policy-related reasons. The most-cited perceived outcomes of day centres fell within the themes of wellbeing promotion and the prevention or delay of deterioration. They felt that attendance and non-attendance were linked with need, preferences, individual resources and age-related preconceptions and that the term 'day centre' was a deterrent. Few commissioners considered centres relevant to supporting people to remain at home, personalisation and partnership working. Yet they, and signposters/referrers, believed there was much potential for them to connect better with and offer more to health and social care. Commissioners expressed interest in outcomes data, contextual data about attenders and how time was spent at centres. In thinking of the future, managers were more concerned with survival, attracting more attenders, demonstrating impact and supporting attenders by having visiting health professionals. Managers and commissioners noted the challenges associated with generating evidence of day centres' impact.

It was thought to be a time of change for both commissioning and for centres. Compared with five years previously, attenders' needs were considerably higher while numbers attending were considerably lower. While changes of funding had not affected the stability or viability of centres, reductions in funding and increasingly onerous grant application processes had been experienced. Authorities differed considerably in their service provision and in their approaches to funding centres.

Referral or signposting to day centres was mainly due to a wish to reduce social isolation, often related to mobility restrictions or dementia, and for carer respite, and based on individual preferences. Signposters/referrers were unaware of any evidence about day centres. Their views and practices mainly stemmed from informally-shared information or their own knowledge.

By presenting centre managers' and local authority employees' views of day centres' current and potential role and purpose, this chapter has built on the descriptions in the previous chapter. The scene is now set for the next three chapters which concern centres' consumers and frontline providers.

Chapter 7 The motivations for day centre attendance, the characteristics of attenders and the use of validated scales within day centres

Elements of research question two (underlined) are addressed by this chapter:

2. Which older people attend day centres and why, what are their experiences of doing so and what are their connections with other parts of their lives?

The chapter starts by outlining the approach taken to gathering data and numbers of attender participants. Using themes that emerged during data analysis, attenders' circumstances at the time they started thinking about attending a day centre and their principal motivation behind this are then summarised. Next, their socio-demographic and health characteristics and social networks are profiled. After setting out overall periods of centre attendance and the frequency of attendance, this is then contextualised by outlining the pattern of attenders' typical weeks.

A secondary aim of this research is to discover whether collecting data about day centre attenders using standardised measures might form a robust evidence base for day centres, which they might find useful in their business planning. The remainder of this chapter outlines the experience of using validated tools with day centre attenders and carers from the perspective of the potential future use of such tools within day centres.

The chapter ends with a summary of its findings.

7.1 Approach to gathering data

Data were gathered in semi-structured face-to-face interviews. In the qualitative part of the interview, attenders were asked what had started them thinking about attending a day centre. Interviews also collected socio-demographic and health data. Some of the categories and questions were guided by KCL's Equality and Diversity monitoring form (health and disability), the Census 2011 (ethnicity and religion) and researcher guidance concerning a sexual orientation question (Haseldon and Joloza 2009). Further data about health, wellbeing and social networks were gathered by administering three validated tools. A fourth was used to measure attenders' and carers' quality of life, the results of which appear in Chapters 8 and 9, but its use is discussed in Section 7.7.4. Participants were also asked to describe their 'usual week' and their activities were mapped onto a template 'map of the week'.

7.2 Summary of the sample of attenders

Attender participants across the four day centres totalled 23: DCHA n=5, DCLA n=7, DCV1 n=5, DCV2 n=6.

As numbers were small in each day centre, data for this participant group were analysed as a whole. In the following sections, attenders' characteristics are mostly set out as one group. Some sections use stacked column charts - which show percentages that each group contributes to a total - to display variations between the centres, since numbers of participants from each day centre varied, and note any marked differences.

7.3 Drivers and motivations for day centre attendance

Participants were asked to recount what prompted them to think about attending a day centre and what was happening in their lives at that stage. Motivations for attending day centres were varied and sometimes multiple. Behind one principal motivation were different clusters of circumstances and drivers which interacted and overlapped, often triggered by an event or a series of interlinked events. Disentangling trigger events from principal motivations was not always straightforward.

Drivers and circumstances were classified into six themes: social isolation, loss of mobility, activity-related, mental health or emotional problems, feeling a need to get out of the house, and carer-related (see Figure 10).

Figure 10: Drivers prompting day centre attendance



As participants often reported several sets of circumstances, numbers do not total 23. Social isolation (n=15) stemmed from being alone (n=10), mainly due to bereavement (n=8), or from having lost existing social networks (n=5). Activity-related circumstances (n=11) included stopping attending another day centre or club due to closure or changed entry criteria (n=6), stopping volunteering (n=2) or retirement (n=1). Some participants wanted 'something to do' (n=3), for

stimulation or a change, or 'somewhere to go' (n=3). Twelve participants had lost aspects of their mobility for reasons of declining physical health (10) or no longer driving their car (n=2). The change in physical health had been sudden for four participants. One former car driver equated no longer driving with losing her independence. Participants with mental health or emotional problems (n=9) felt depressed or very low (n=6), were lonely (n=3), had lost confidence (n=1) or reported a diagnosed anxiety disorder (n=1). Of the seven participants wanting to get out, one did not get out enough, and six described being 'stuck' at home. Of the circumstances related to caring, one participant recognised the need for her daughter to have a break, one felt isolated as a spousal carer and the third cared for her husband who had been referred to a day centre, and she accompanied him. The two summarised and anonymised examples in Box 8 illustrate the complexity of attenders' circumstances when they started thinking about attending a day centre.

Box 8: Examples of two attenders' circumstances before attending a centre

Loss of confidence and depression following widowhood led Ruth to stop driving her car. Doing so resulted in lost social networks and activities due to being unable to get out. The situation worsened after a period of illness which left her unable to walk to a nearby volunteering commitment. She lived alone and wanted social contact which she had lost after stopping driving.

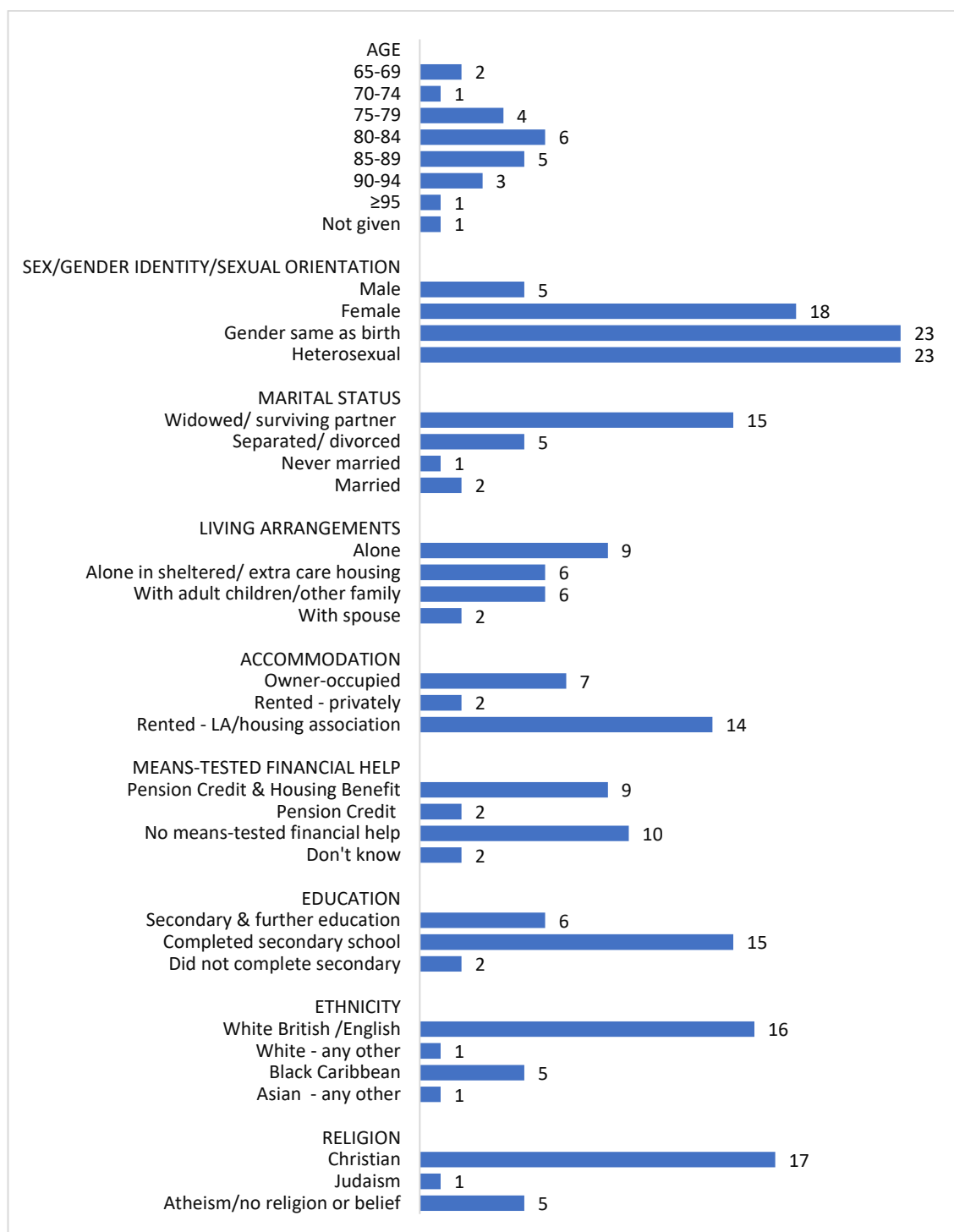
Wilma fell ill immediately after being widowed. She lost physical mobility and, consequently, social networks, despite her son and his family living in the same house. Wilma wanted a change of environment but was unable to get out without help.

Principal motivations for starting to attend a day centre reflected these circumstances. The most common principal motivation for was a desire for social interaction (n=10), with two participants stating their preference for contact with people in the same age group. The joint second most common was activity-related (n=4) which covered wanting to do something (n=2), something stimulating (n=1) or something useful (n=1). The next main motivator, alongside activity, was to get out of the house (n=4). Two people's main motivation was for physical health through exercise (n=2), one having been referred for group activity. For two of the remaining three attenders, motivations were meals (n=1) and to improve mental health (n=1). The final participant had started to attend with her husband, for whom she was a carer, but was unclear about the reasons behind her attendance.

7.4 Socio-demographic profile of participants

Participants' socio-demographic characteristics are summarised in Figure 11. Each of the sub-sections that follow covers different aspects of attenders' socio-demographic characteristics in more detail.

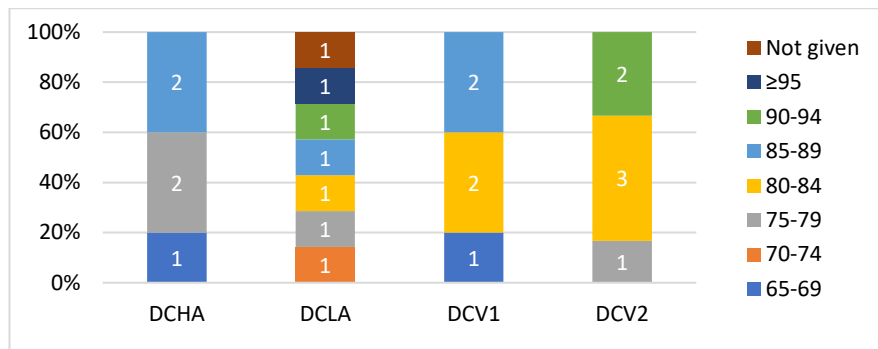
Figure 11: Socio-demographic characteristics of attender participants



7.4.1 Age

Based on data from 22 participants, as one refused to supply her date of birth, participants' average age was 83.3 years. Ages ranged from 68 to 101 years. Thus, there was a 33-year difference between the youngest and the oldest, the equivalent to a generation or more. Highest numbers of people were in the 80-84 (n=6) and the 85-89 (n=5) groups which encompassed participants' median age of 83.5 years and their mode age of 88 years. Half were aged in their 80s (n=11), seven were younger than this, and four were older. DCLA was the most age-diverse centre (see Figure 12).

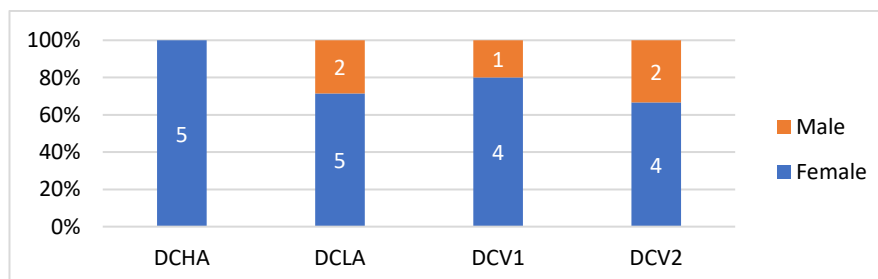
Figure 12: Attenders' age groups



7.4.2 Sex, gender identity and sexual orientation

Female participants (n=18, 78%) outnumbered males (n=5, 22%) with a ratio of 3.6:1. No participant had changed gender since birth. All participants reported their sexual identity to be heterosexual/straight except for one at DCV1 who said he 'couldn't answer' the question. This participant was never married and had a learning disability. The gender split approximates the proportions observed to attend all four centres during fieldwork (n=68, 73% female). None of DCHA attendee participants were male (see Figure 13).

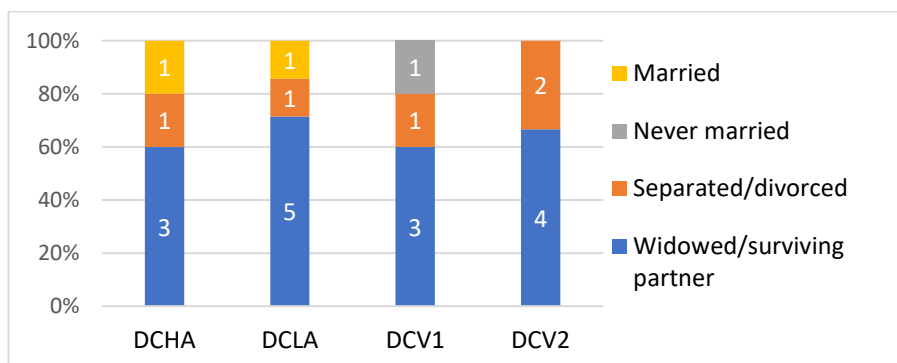
Figure 13: Attenders' sex



7.4.3 Marital status

The majority of participants were single ($n=21$, 91%) for reasons of widowhood ($n=15$, 65%), separation or divorce ($n=5$, 22%) or never having married ($n=1$, 4%). Two were married (8%). Figure 14 displays marital status by day centre attended.

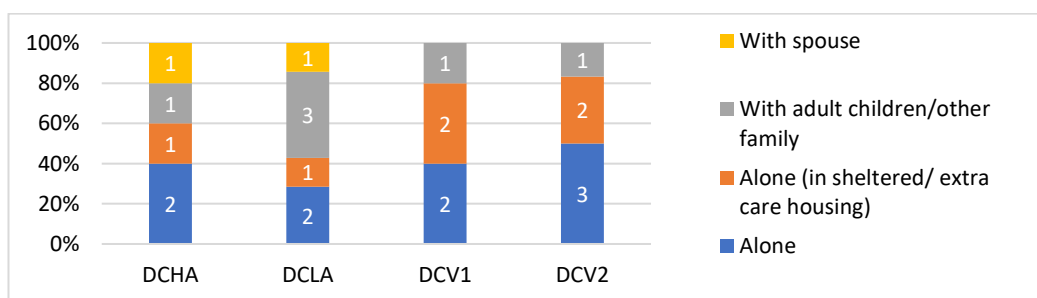
Figure 14: Attenders' marital status



7.4.4 Living arrangements

Two-thirds of participants lived alone ($n=15$, 65%). Six of this group (26% of all attenders) lived in sheltered or extra care housing and may have had easier access to other people and support than those living alone in other types of accommodation. Six (26%) lived in accommodation shared with adult children ($n=4$) or grandchildren ($n=2$). One female and one male attender lived with their spouses ($n=2$, 9%). Figure 15 displays this by day centre. Slightly higher numbers of attenders of DCV1 and DCV2 lived alone than at DCHA and DCLA. The former two targeted socially isolated older people.

Figure 15: Attenders' living arrangements

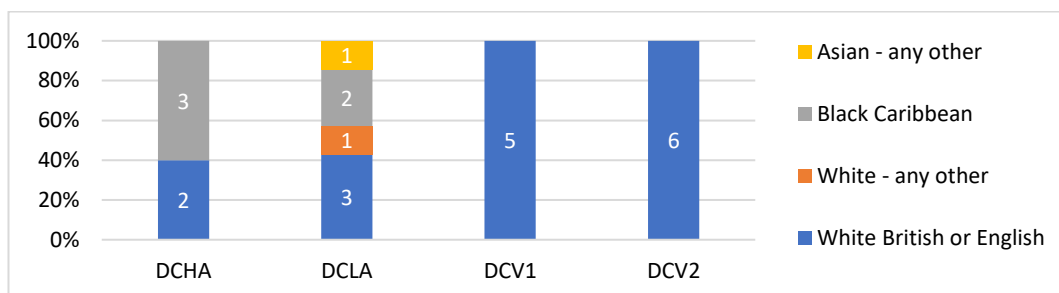


Attenders had lived in their local areas for an average of 40.5 years each (range 10-84 years).

7.4.5 Ethnicity

Of the White participants (n=17, 74%), who accounted for almost three-quarters of participants, 16 were White British/English, and one was Southern European. Five participants were Black Caribbean (21.73%), and one was Any Other Asian (4%). Figure 16 shows there was no ethnic diversity among participants attending DCV1 and DCV2, which reflected these centres' overall users. DCV2 was in an area with very low ethnic diversity. Diversity was greater where DCV1 was located, but non-White British/English groups were mainly younger in the local population.

Figure 16: Attenders' ethnic groups



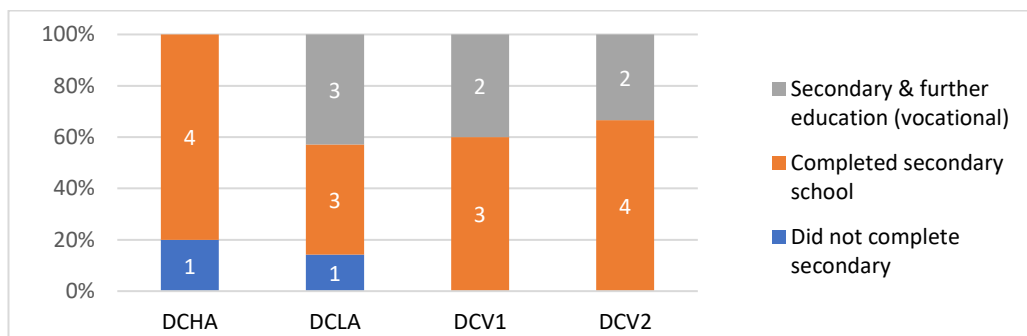
7.4.6 Religion

Christianity was the reported religion of almost three-quarters of participants (n=17, 74%). One was Jewish, and five (22%) were atheists or held no religious beliefs.

7.4.7 Education levels

Almost one-third (n=7, 30%) of participants had obtained further qualifications, all vocational, beyond secondary school. Almost two-thirds of participants had completed secondary school (n=14, 61%) and only two had not (9%). Reflecting the school leaving age at the time, many of those completing secondary school had left aged 14 or 15 years. No attenders of DCHA had gained qualifications beyond secondary school whereas two or three at the other centres had (see Figure 17).

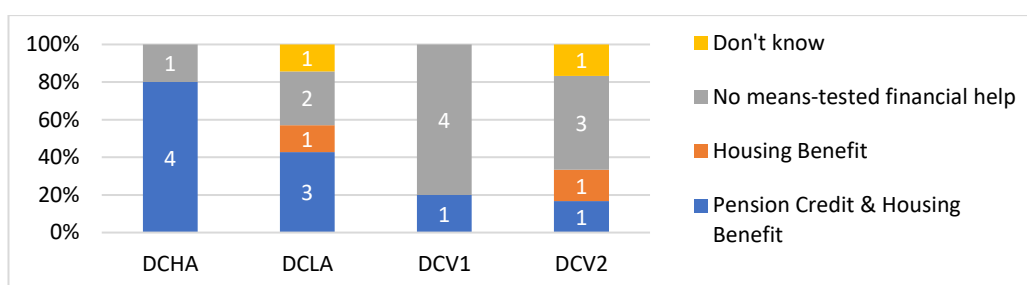
Figure 17: Attenders' education levels



7.4.8 Financial circumstances

Similar numbers of participants received means-tested benefits (n=11, 48%) as those who did not (n=10, 43%). Two did not know about their financial circumstances. The balance of attenders receiving and not receiving means-tested benefits in DCHA and DCLA was in contrast to attenders of DCV1 and DCV2, the majority of whom self-funded and had not undergone a social services' needs assessment.

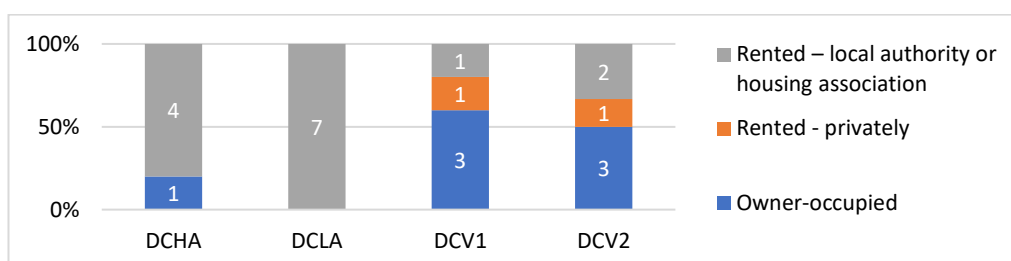
Figure 18: Attenders' financial circumstances



7.4.9 Accommodation

Almost two-thirds of attenders lived in accommodation they rented from the local authority or a housing association (n=14, 61%) and almost one-third were owner-occupiers (n=7, 30%). A small number rented privately (n=2, 9%). Figure 19 shows that proportions of owner-occupiers were highest in DCV1 and DCV2. All or almost all attenders of DCLA and DCHA rented from the local authority or a housing association.

Figure 19: Attenders' accommodation



7.5 Health characteristics and social networks of participants

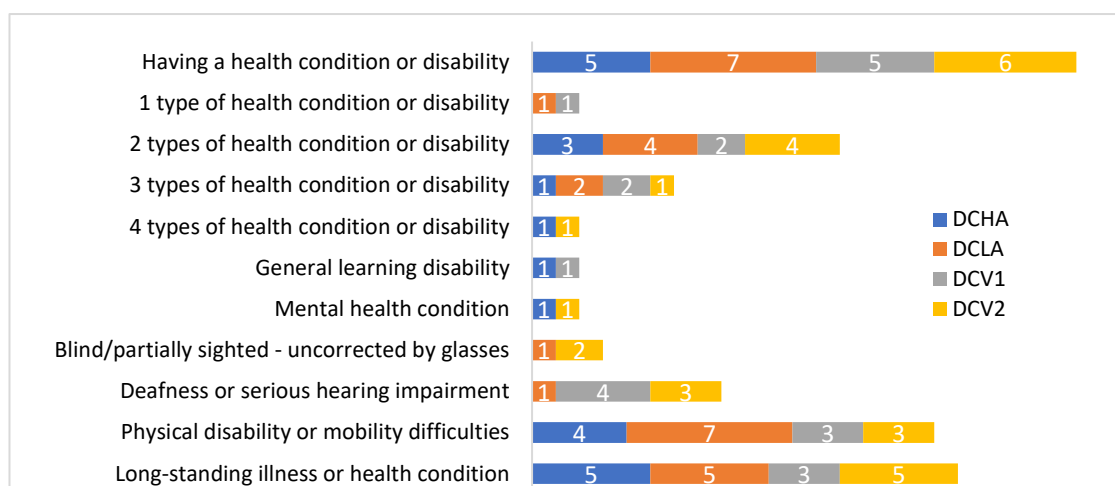
This section describes participants regarding their health status and social networks.

7.5.1 Health conditions or disabilities

All participants reported having at least one category of health condition or disability where disability was defined as a physical or mental impairment which has a substantial long-term adverse effect on the ability to carry out normal day-to-day activities (see Figure 20). Half (n=13, 57%) reported two types of health condition or disability, a quarter (n=6, 26%) reported three types, two reported four types (9%), and two reported one type (9%). The most prevalent types,

reported by three-quarters, were long-standing illnesses or health conditions (n=18, 78%) and physical disabilities or mobility difficulties (n=17, 74%). One-third (n=8, 35%) reported deafness or serious hearing impairment. Being blind or partially sighted, to the extent that this was uncorrected by glasses, and having another type of condition were each reported by three participants (13%). Those with mobility difficulties or physical disabilities used walking sticks (n=6), walkers (n=6), wheelchairs (n=4) or crutches (n=1) at their day centres. While deafness was more prevalent at DCV1 and DCV2, higher levels of mobility difficulties and more long-standing health conditions were more prevalent at DCHA and DCLA. Health conditions were under-reported by attenders. Some did not report certain health conditions in the interview that I was later made aware of in carer interviews, by staff during discussions or by the attender themselves, for example, that one participant had dementia and another had terminal cancer and had had a stroke.

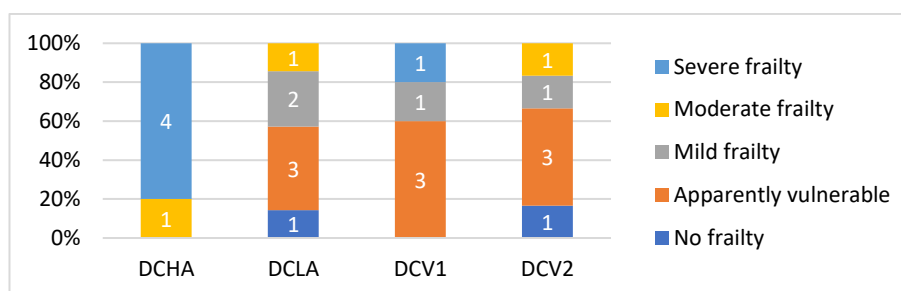
Figure 20: Attenders' health conditions or disabilities



7.5.2 Frailty as measured by the Edmonton Frail Scale (EFS)

Starting at the lowest level, two participants had No Frailty. Two-thirds were Apparently Vulnerable (n=9, 39%) or had Mild Frailty (n=4, 17%). Three were Moderate Frail (13%) and five Severe Frail (22%). Figure 21 shows that participants attending DCHA had the highest frailty levels. Levels of Apparent Vulnerability were matched across the remaining three centres.

Figure 21: Attenders' frailty as measured by the Edmonton Frail Scale



7.5.3 Wellbeing as measured by the Short Warwick-Edinburgh Mental Well Being Scale (SWEMWBS)

From existing examples, Taggart *et al.* (2015) state the importance of presenting wellbeing data categorically. Following their example, scores within one standard deviation above or below the mean are categorised here as ‘average wellbeing’, with remaining scores below this categorised as ‘poor wellbeing’ and those above it as ‘good wellbeing’.

Figure 22 shows that 13 (59%) of the 22 participants completing the tool had average wellbeing, while wellbeing was good for 4 (18%) and poor for 5 (23%). Scores lay in the upper two-thirds of the possible score range (7-35 raw, 7.00-35.00 metric). Metric scores ranged from 17.43-35 (18-35 raw score), with an average of 24.78 (27.18 raw score) and a standard deviation of 5.09 (5.16 raw score). The highest proportion of poor wellbeing was at DCV1 (see Figure 23).

Figure 22: Attenders' levels of wellbeing as measured by the SWEMWBS

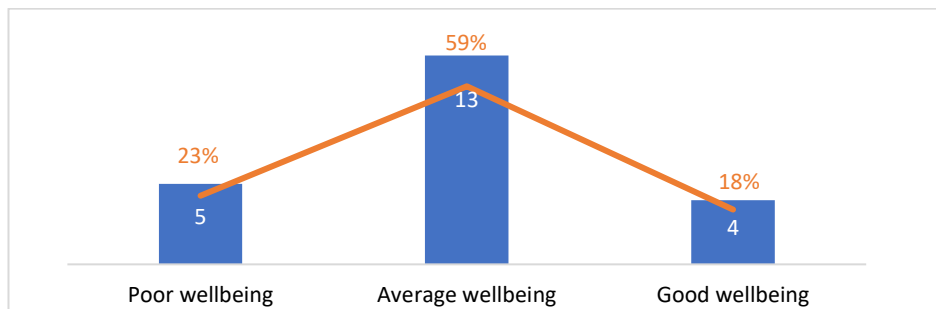
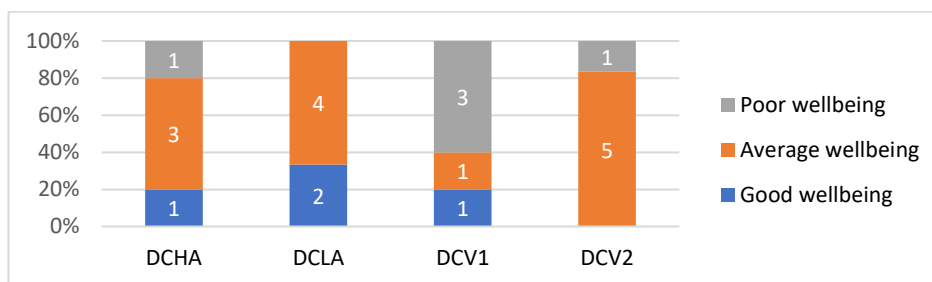


Figure 23: Attenders' wellbeing by centre

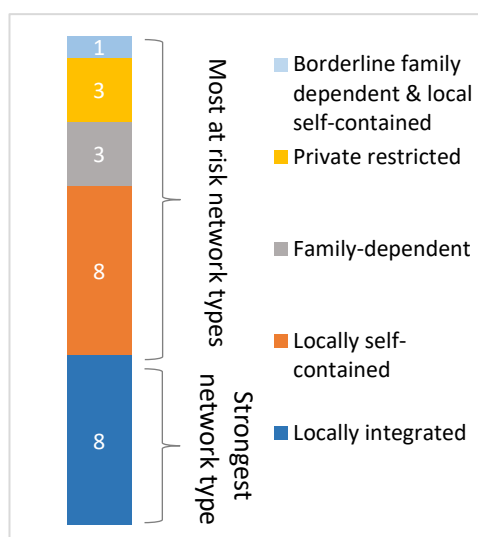


7.5.4 Social networks as measured by the Practitioners Assessment of Network Type (PANT)

Initially, only two-thirds (n=15) of attenders had a clear social network type. To identify a single network type for participants whose scores were equal across two (n=7) or four network types (n=1), data were entered into SPSS. An algorithm was then applied which classified ‘ties’ using previous knowledge of which network is most likely (Wenger 1994, 1996). The following paragraphs detail participants’ resulting network types, with descriptions taken from Wenger (1997).

One-third of attenders had a strong social network type (see Figure 24). Locally Integrated (n=8) or Wider Community-focused (n=0) networks are the strongest types. In the former, informal help is exchanged between family, friends and neighbours, and people have community group involvement. People with Wider Community-focused networks do not have local family, but exchange informal help with friends and are in contact with family over 50 miles away; there is some neighbour involvement and high community group involvement.

Figure 24: Attenders' social network types

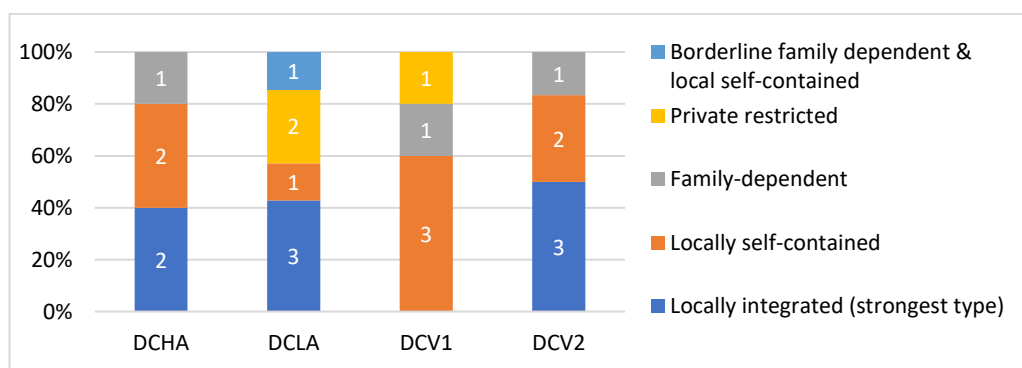


Two-thirds of attenders had networks with associated risks. People with Locally Self-Contained networks (n=8) are more likely to be isolated than people with stronger network types (Wenger *et al.* 1996) as people rely on neighbours, lead private lives and have little community involvement. They are, however, in contact with family over 50 miles away. Family Dependent (n=3) and Private Restricted (n=3) networks carry greater risks of depression, loneliness and other mental ill-health (Wenger 1997). People with the former type rely on

local family, but also have some neighbour contact and some community group involvement. People with the latter have no local family, no local informal support and little community contact, but people may rely on far away family. One attendee's network was on the borderline between Family Dependent and Locally Self-Contained (n=1), thus was also at risk.

Figure 25 shows that all attenders of DCV1 had an at-risk network type. This was also the centre with highest levels of poor wellbeing.

Figure 25: Attenders' social network types by centre



7.6 Day centre attendance: frequency and context

Participants' reported total length of time attending their day centre and their frequency of attendance are reported in this section. Attendance is then contextualised within participants' usual weeks.

7.6.1 Length of time attending a day centre

Some discrepancies emerged between interview self-reports and previous information shared during fieldwork or data provided by day centres. Without access to day centre attenders' personal records to verify self-reports, I used data provided by centres where data conflicted. One attender did not talk in the interview about when she started attending but had mentioned it during my visits. A few were unsure exactly how long ago they started, but their estimates slotted into the time periods I had established.

Figure 26 shows that five participants had started attending within the previous 12 months (22%). The largest group was those attending for 1-5 years (n=9, 39%). Three had been attending for 5-10 years (13%). The second largest group was of very long-term attenders (>10 years) (n=6, 26%), one of whom had been a regular for 32 years.

Figure 26: Length of time attending centres

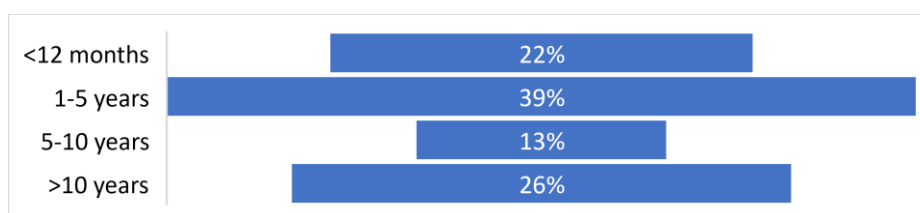
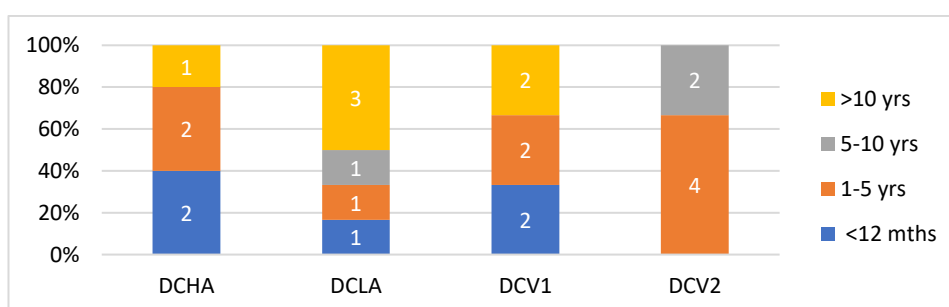


Figure 27 shows that, while the length of time attending DCV1, DCLA and DCHA ranged from less than a year to ten years or more, none of those attending DCV2 had attended for less than 12 months or over 10 years, which may have been related to changes in management over the previous year (see Box 7 in 5.5.3).

Figure 27: Length of time attending by centre

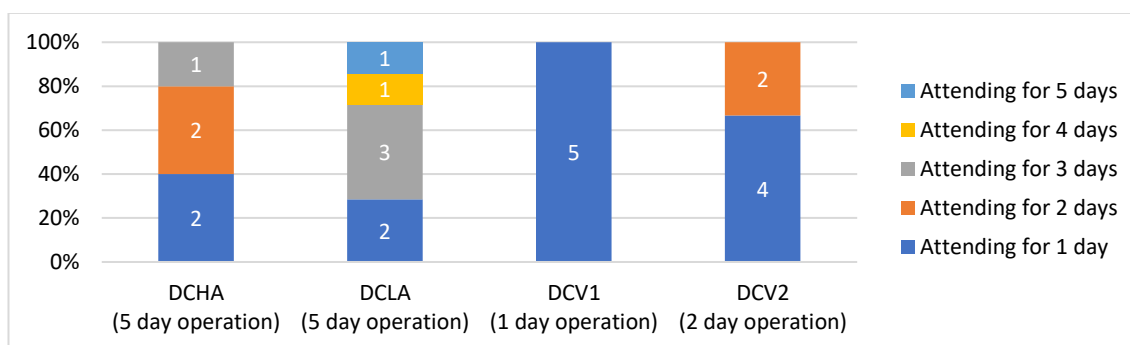


7.6.2 Frequency of attendance

The frequency of attendance ranged from 1-5 days, but attenders of DCV1 and DCV2 were restricted to one or two days, respectively, which were the number of operational days (see Figure 28). Two-thirds of DCV2 participants attended on both operational days. Only one participant from DCHA or DCLA attended for all five days, and only one attended for four days.

Average weekly attendance was for 1.8 days. Overall, just over half (n=13, 56%) attended once a week, one-third (n=8, 35%) for two (n=4) or three (n=4) days and two (9%) for four or five days a week.

Figure 28: Frequency of attendance



It would have been interesting to analyse frequency of attendance in relation to frailty levels and living arrangements to consider the extent of day centre usage as part of care packages for very frail older people, but the small sample size means this is impractical.

7.6.3 Attendance contextualised within a 'usual week'

Six attenders' usual weeks are summarised in Box 9, to give an overview of the differing patterns of attenders' weeks, and two Maps of the Week appear in Appendix 13 for illustrative purposes. The following paragraphs provide an overview of the frequency and types of regular activities undertaken by attenders. Activities are categorised into personal care, home care help, family, structured and unstructured non-familial social events, educational activities, medical appointments and miscellaneous events.

In addition to their day centre days, attenders left their homes on 1.3 days every week, on average. The number of additional days, on average, that attenders went out ranged from none to 3, plus monthly outings. Five attenders' only weekly outing was to their day centre. Nine participants had one further weekly outing, four of whom also had fortnightly or monthly outings. Four had a further two weekly outings, and three went out on three days. Two undertook a fortnightly outing in addition to their day centre day. Three had one additional weekly trip out plus an additional fortnightly outing, and one of whom also undertook an additional monthly outing.

Ten attenders managed their personal care without paid support; they attended DCLA (n=4), DCHA (n=1), DCV1 (n=2) and DCV2 (n=3). Four had weekly (n=3) or monthly (n=1) home visits from hairdressers, but no other personal care help. Nine attenders had help with personal care from care workers for seven (n=6), five (n=2) or two (n=1) days a week.

Thirteen attenders had no paid home care help. Eight had once weekly help with housework from home care workers, cleaners or neighbours. Two had these visit every day. Of these, one had daily help with washing up, bed-making and vacuuming and the other, in addition to having help with housework, also paid a neighbour to cook and deliver a daily evening meal. Family members undertook housework for two attenders.

Seven attenders saw family members frequently, either daily (n=1) or five (n=1), three (n=2) or two days a week (n=3). Ten saw family members once weekly; two of whom also saw them fortnightly and monthly. Two attenders saw family fortnightly or monthly. Three saw family irregularly or not at all. Three had short or long telephone conversations with adult children at least twice weekly.

Fifteen attenders had no structured non-family social events. Two attended another day centre or social club once weekly. One had a weekly evening bingo outing. Five went on monthly outings to lunch clubs (n=3) or coffee mornings (n=2) run by the day centre provider, and/or monthly 'tea parties' (n=2) run by a charity.

Sixteen attenders had no regular unstructured non-familial social events. Seven regularly met with friends, some more than once a week, either receiving home visits (n=5) weekly (n=3), fortnightly (n=1) or monthly (n=1), or visiting their friends' houses fortnightly (n=3), having been driven there. Two went out with friends, one having been driven by their friend. One had weekly social visits from a neighbour, and another's neighbour did her shopping weekly and stayed for a chat.

Only two participants were enrolled in educational activities; both attended a skills centre for the visually impaired to learn, for example, how to use computers.

Three attenders had regular medical appointments and one kept one day every week free for appointments. Of these, one usually visited the GP weekly, another was visited at home on the two non-attendance days for insulin injections and the third spent three days a week at hospital for dialysis.

Eight attenders undertook weekly or fortnightly food shopping outings, six with support from family (n=2), friends (n=2), dial-a-ride (n=1) or a voluntary organisation support worker (n=1). The support worker also accompanied the attender to appointments and did paperwork. Two attended

church, weekly (n=1) or fortnightly (n=1), and two received Holy Communion at home from visiting priests, one weekly and one monthly. Finally, one did weekly exercise at a gym.

Box 9: Six attenders' usual weeks

Bob: Lives with adult child who frequently travels. Attends day centre twice a week. Goes food shopping twice a week with son or by bus.

Dorothy: Lives with adult son. Attends day centre on three days. Goes by taxi to church fortnightly with son. Other son visits weekly for an hour.

Kathleen: Lives alone in extra care block of flats. Attends day centre once weekly. Care worker washes up, makes bed and vacuums for 30 minutes every morning. Her two adult children each visit once a week (for 4 and 5 hours); one delivers shopping and takes her out for a walk. Priest from local church visits to give Holy Communion once weekly (30 minutes). Hairdresser visits weekly (1 hour) and takes to supermarket for food shop fortnightly.

Rosemary: Lives alone in extra care block of flats. Attends day centre once weekly. Has regular GP visits on one day, after which she does food shopping and goes to hospital appointments with a voluntary organisation support worker who also does her paperwork (2.5 hours) and eats lunch with her at her home afterwards. Attends weekly skills centre for visually-impaired to learn how to use a computer (4 hours). Hairdresser visits for an hour weekly. One day during the weekend, she visits her daughter for the whole day. She attends a monthly two-hour lunch club organised by the day centre provider.

Thomasina: Lives alone. Attends day centre once weekly. Adult son visits once a week for 3 hours. Cleaner comes weekly for two hours, does shopping and sometimes takes her out.

Wilma: Lives with adult son and his family; both adults work full-time. Attends day centre once weekly. Attends another day centre once weekly. Privately organised care worker visits Mon-Sun in the morning (1.5 hours), at tea time (30 minutes) and in the evening (1.5 hours) to help Wilma get up, washed and dressed; she changes her incontinence pads, prepares breakfast, tea and refreshments and helps her change for bed. She also visits on the five days Wilma is not at a day centre to change her pad and make her lunch. A cleaner works for an hour every week. One daughter visits one day at the weekend, arriving late morning and leaving in the early evening. Another daughter or granddaughter visit for 3 hours on the other weekend day. Every month, the local priest visits briefly to administer Holy Communion.

Additional current context

In interviews, some participants spoke about their characters or their lives more broadly, providing some further current context.

Home maintenance and self-care had become, or was becoming, increasingly effortful for many. One said she could no longer cope with group family visits and was finding seasonal activities (e.g. leaf-sweeping) too much. She had decided to sell her home and buy a 'sheltered' flat. A second was finding 'little things' (e.g. taking curtains down to wash) difficult and was considering finding out about help with housework, but wanted to retain her independence for as long as possible. A third laughed as she recounted the last time she had a bath which was the day she discovered she was no longer able to get out of it. A fourth was sad she could no longer maintain her garden which had been her pride and joy. One, however, reported still mowing the lawn and digging the garden.

While some attenders talked about how independent they had always been, one was still mourning her recent loss of independence. There was a sense of resignation to the situations in which they found themselves, in that some had adjusted to these. One would have loved to go out for walks

but her unsteadiness made her nervous, and her children had discouraged her from doing so as the rurality of her area meant nobody might find her if she fell, and mobile telephone networks were not always available. One attender talked about the two weekdays she did not go to the day centre:

'I've got the television, and I've got the care line [telephone alarm system] and you know, things like that. I don't mind.' (Dorothy)

A small number mentioned how helpful neighbours were. One provided hot meals and another locked a participant's front door for her.

A few attenders considered themselves to be 'joiners' and one classed herself as 'very friendly'. The list of clubs one attender had belonged to was long; it included bowls, a gardening group, golf, keep fit, handicraft and the University of the Third Age (U3A) (a membership organisation of older people who create their own education, creative and leisure opportunities in small local groups, often meeting in members' homes). Another had been a member of the Women's Institute and another club. Some had also been active citizens, talking about their voluntary work, for example at community centres or with a Pensioners' Action Group. A few said they had not been joiners, with one classing herself as unsociable; she enjoyed her own company and did not like to 'bother' people.

7.7 The use of validated scales

This section recounts and reviews the experience of administering standardised measures from the perspective of their potential future use, either as background data for use in the day centre's business planning, for monitoring purposes or any other reason, for example as evidential data for funding bodies. Use with both attenders and carers is covered since day centre attendance may be for carers' benefit.

Scales were described and their strengths and limitations outlined in Chapter 3 (see 3.4.4). Four were used with attenders:

- Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)
- Edmonton Frail Scale (EFS)
- Practitioner Assessment of Network Type (PANT)
- Adult Social Care Outcomes Toolkit (ASCOT) INT4

Two were used with carers:

- Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)
- Adult Social Care Outcomes Toolkit (ASCOT) INT4 Carers

The administration of EFS, PANT and ASCOT was supported by large print 'showcards' which displayed the questions and, for PANT and ASCOT, the answer options (see example in Appendix 4). Large print showcards were not used with the SWEMWB since this was required to be used in its

original format. I read questions to most interviewees and, for PANT, ASCOT and SWEMWBS, the answer options.

Each tool is the subject of one of the following sub-sections. The two ASCOT scales are covered together due to their similar structure. Background data of note are that two attenders had a mild learning disability and all but two were first language English speakers, although this is not relevant to all tools.

7.7.1 Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

The SWEMWBS was found to be quick and easy to use with attenders who experienced no problems comprehending or responding to questions. Although used with all attenders, it was timed with 19 of them. Its administration took 1-7 minutes, with average, median and mode times of two minutes.

Two of its acknowledged limitations concern age and ethnicity (see 3.4.4). That one attender, aged 81, was unable to answer to what degree she had been feeling optimistic about the future, saying that she did not think about the future, perhaps reflects its validation for use with people aged 13-74. The average age of attenders was 83.3 years. This meant that complete scores were gained for 22 attenders. Although not validated with this group, its use was encouraged, by its developers, with Black or Afro-Caribbean populations. This study used it with five Black Caribbean older people, one of whom was the aforementioned person who did not think about the future. No further problems arose.

The scale's robustness had not been tested when reading questions out or completing it unseen. Nevertheless, I read questions and answer options out to two visually-impaired attenders and to one who could not read, repeated these where it appeared necessary due to long pauses, or when requested. This did not seem problematic.

Long administration (7 minutes) with one of the two participants for whom English was not their first language was more reflective of the entire interview than language.

Use of the SWEMWBS with carers was also quick and easy, taking from 1-3 minutes. Average time taken was one minute, which was also the mode. The median time taken was 1.5 minutes.

Although data gathered are presented in this thesis in terms of wellbeing categories (Section 7.5.3 and Chapter 8), their envisaged practical use would be to monitor individual wellbeing change, potentially at the start of attendance and thereafter. Thus, in addition to being an overall impact measure, it may form part of individual monitoring.

7.7.2 Edmonton Frail Scale (EFS)

Although used with all attenders, use was timed with only 19 of them. The EFS took 2-34 minutes to administer, with an average of six and a median of five minutes. Mode times were four and five minutes. As for the SWEMWB, long administration (34 minutes) with one of the two non-first language English speakers was more reflective of the entire interview than language, with the participant providing additional and historical background information to each question. While mindful of its cognitive testing limitations, detailed below, I concur with Perna *et al.* (2017) concerning its convenience and ease of use. As a non-geriatrician, I found it easy to implement, as intended (Rolfson *et al.* 2006). It also provided interesting data about attenders' general health and frailty status, perhaps useful for profiling attenders as a group.

Challenges arose concerning scoring for visually-impaired or illiterate attenders or those with limited hand mobility. Whereas the Timed Up and Go Test (TUG) scores a fail if a person is unable or reluctant to carry it out or if safe performance requires aids, there is no such scoring provision for the Clock Drawing Test due to sight impairment or hand mobility. Visually-impaired people were excluded from two studies testing the EFS (Hilmer *et al.* 2009, Rolfson *et al.* 2006). EFS guidance suggests that carer input may be required should it be failed as this suggests major cognitive impairment, but these papers did not indicate that administration should be stopped should a person fail. I consulted Rolfson, the tool's author, who agreed that clarity of guidance was needed and that the lack of provision for such circumstances was a design weakness. Although reluctance or inability to perform the TUG suggested risk of falls, similar to poor performance in TUG, cognitive impairment could not be inferred from reluctance or inability to perform the Clock Drawing Test, particularly if due to other impairments. In practice, but not necessarily in research, in such cases one may employ a different screening tool, scoring the outcome as EFS indicates. Rolfson commented upon another version he had developed (EFS20 for which I was unable to locate references) which increases points for this domain from two to five and requires copying intersecting pentagons (2 points) and spelling the word 'world' backwards (3 points, one for each error). This, however, also requires vision and hand mobility and would be failed by someone unable to read. Since Rolfson also highlighted the importance of consistency, because attenders under-reported health conditions (see 7.5.1) and since EFS is for descriptive not diagnostic use, I decided that failure of the Clock Drawing Test for the aforementioned reasons indicates deficit, whether cognitive or otherwise, and scored six attenders a fail. These six were visually impaired (n=2), unable to use fingers well due to stroke (n=1), said their fingers 'did not work properly' (n=1), were unable to read or write (n=1) and, finally, a diabetic attender tried but said all she could see was black dots.

7.7.3 Practitioner Assessment of Network Type (PANT)

Administration of PANT was timed with 19 of the 23 attenders it was used with. It was easy to use, non-intrusive and took 2-15 minutes to administer. On average, its implementation took 4 minutes, with a median of three and a mode of two minutes. Longer administration time was due to conversation arising from questions or not knowing how far away a relative lived. In the latter cases, I asked for names of locations to look up distance later. Answers were scored as 'no relatives' for three attenders with estranged children or who did not know where siblings lived.

Despite its objective focus, PANT provides valuable data concerning potential future risk and need for additional services that may be useful for centre providers to be aware of, although its updated version is likely to be more relevant in the current environment.

7.7.4 Adult Social Care Outcomes Toolkit (ASCOT) INT4

ASCOT INT4 was completed with 22 attenders. Average administration time was 15 minutes, with time ranging from 6-33 minutes. The median (14 minutes) and mode (15 minutes) times suggest that the average is indicative of actual administration time.

ASCOT was not completed with one attender who had appeared to understand the questions and the nature of the hypothetical situations but, after several questions, started to talk about what she liked and wanted to do instead of focusing on the questions. This attender had a mild learning disability and a short-term memory problem due to brain injury. Since the other participant with a mild learning disability did not have major difficulties with ASCOT, it is possible that the questions and answers were too long for the attender concerned to process even though she apparently understood them.

As previously, longer time was partly indicative of a specific participant's whole interview and her desire to supply additional, incidental detail, but also her level of deafness and difficulty understanding the questions which necessitated considerable explanation, possibly because her first language was not English. This attender's answers did not always reflect the information supplied in the qualitative part of the interview, during which she had said that the centre felt like a second home, hence the ASCOT gain score may have undervalued its contribution to her quality of life. Two first language English speakers had difficulty imagining a hypothetical situation without the centre, saying that they would never be without any support as the people around them would visit or organise an alternative. Another requested that I inform the tool's developer that she would not have understood the filter and hypothetical questions, which she felt were unclearly worded, had I not been present to explain what they meant. Many attenders appeared to be slightly confused by these questions and some level of clarification was needed before they were happy to answer.

The word 'affect' in the filter questions appeared to have negative connotations for many attenders. There were some attenders who, given the content of their qualitative interviews, I believe may have chosen a different answer to this question had the phrase 'make a difference' been used instead. Some such interviewees, whose responses did not tally with their qualitative interview content, wanted to move on quickly and others may have been offended had their understanding been questioned. This may also have meant that, for some, ASCOT gain scores undervalued actual gain.

A small risk identified had been that some participants may have already completed a shorter ASCOT self-completion questionnaire in the postal Annual Social Care Survey carried out by local authorities. However, no participants mentioned this. Another risk identified had been the potential for respondent fatigue, given ASCOT's length and that it was administered after a qualitative interview. Interviewees did not appear fatigued; even those experiencing difficulties with questions were very engaged. A further risk related to attenders' funding. Almost two-thirds of participants self-funded their centre attendance and this tool was designed for use with publicly-funded attenders, whether full or partially-funded. When the tool was tested, eligibility for services was set at lower level than currently (Dunning 2010); and it is possible that self-funders in this study may have met the eligibility criteria of having 'low' or 'moderate' needs that have since been eliminated. Nevertheless, it is also recognised that, even so, they may still have self-funded due to their levels of resources. I do not believe this was problematic since centres themselves received public funding.

ASCOT INT4 Carers was used with all ten carers, taking 7-17 minutes to administer, with the average being 10 minutes. Median (9.5 minutes) and mode (8 minutes) timings suggest the average is representative of actual time taken. Most carers answered without hesitation, appearing to have no comprehension problems.

The small samples in this study meant calculations of whether the gain experienced was statistically significant and whether the services were cost-effective were inappropriate. Furthermore, to make full use of ASCOT as a cost-utility tool, cost data per place is needed which this study did not obtain. Funders are likely to be keen to know both the statistical significance of gain and whether a day centre is cost-effective.

Despite these limitations, its length and the challenges detailed above, this research found ASCOT a valuable tool for demonstrating the value of day centres to individuals, particularly since its findings corroborated qualitative findings. However, due to its unwieldiness, the use of large print showcards with attenders was found to be imperative, even more so for the hearing-impaired.

7.8 Summary

Drivers behind and motivations for day centre attendance were mainly related to loss or the desire to have something different in their lives. Although length of attendance stretched from a few months to decades, these motivations are likely to reflect attenders' marital status, living arrangements and health. At fieldwork, half were aged 84 years or older, most were widowed or divorced and two-thirds lived alone. All participants reported having health conditions or disabilities that impacted greatly on their day-to-day life, with half reporting at least two types of these. All, except two, had some levels of apparent vulnerability or frailty when general health status was measured with the EFS.

Three-quarters of participants were women. Almost one-third had education extending beyond secondary school. Similar numbers received means-tested benefits as those who did not. Again indicative of relative deprivation, two-thirds lived in rented homes while just under one-third were owner-occupiers. Three-quarters held religious beliefs. Ethnic minority groups accounted for a quarter of the total number, but were only in two of the four centres, reflecting local demographics. Attenders' regular activities outside their day centres varied, but most did not go out of their homes very often and some usually had very empty weeks.

Apart from marital status and living arrangements, the profiles of attenders at the four centres varied between centres. DCLA was most age-diverse, and DCHA was the least gender-diverse. DCHA and DCLA had the highest levels of mobility difficulties and more long-standing health conditions, and deafness was most prevalent at DCV1 and DCV2. Owner-occupiers prevailed at DCV1 and DCV2 and renting at DCLA and DCHA.

Three-quarters of attenders had average or good wellbeing when measured with the SWEMWBS. One-third had strong social network types, while two-thirds of attenders had networks with associated wellbeing risks, when networks were measured with PANT.

This research found that use of validated tools in day centres did not involve excessive time or effort. Having built a rapport with participants, none of the validated tools felt intrusive to administer, and those measuring wellbeing, frailty levels and social networks were very quick and easy to use. They would seem easy to incorporate into assessments and reviews carried out within day centres. ASCOT, although cumbersome in length, emerged as a useful, single-use tool to provide evidence of impact.

Chapter 8 The outcomes for and experiences of older attenders

Having covered the motivations for day centre attendance and the characteristics of attender participants in Chapter 7, attenders' outcomes and experiences are the subject of this chapter which addresses elements of research questions two and three (underlined):

2. Which older people attend day centres and why, what are their experiences of doing so and what are their connections with other parts of their lives?
3. What are the outcomes of day centre attendance for older people, their carers, and volunteers, and of staff working at them?

This chapter presents the findings from interviews with individual older attender participants within the case study sites to help answer these questions. It comprises qualitative and quantitative data which are summarised together and then presented separately. As explained in 3.5.3, findings for the whole participant group are presented together rather than being analysed by each day centre due to the small sample size and consequent problems for conclusion-drawing and compromising anonymity. However, analysis in this chapter highlights some overall differences in outcomes between the centres.

After opening with an outline of the approach taken to gathering data, this chapter summarises, in tabular form, both qualitative and quantitative data concerning outcomes, the unique contribution attendance makes to participants' lives, and their favourite aspects of attendance, with an accompanying commentary. Next, the findings of quantitative measurement of outcomes are presented. The following section provides further detail on the seven outcome themes identified in the qualitative data and related experiences. It starts with an analysis of how these outcomes were distributed across individual characteristics and day centres and ends by presenting experiences that are likely to have contributed to process outcomes. After this, attenders' other experiences, concerning finding out about centres, payment, transport, age-related frailty, the value of continuity and attenders' least favourite things and suggestions for change, are summarised.

Carers' and day centre volunteers' and staff's perceptions of the impact of centre attendance on attenders are then set out, for example what carers think their relatives gain from day centre

attendance. Managers' and local authority employees' perceptions of outcomes gained by attenders were covered in Chapter 6. The chapter ends with a summary of attenders' outcomes and experiences.

8.1 Approach to gathering data

Mixed methods in face-to-face interviews with attenders gathered data about outcomes of attendance. Data about views and experiences were gathered qualitatively in interviews. On average, full participant interviews lasted 92 minutes (range 68-230 minutes), with the qualitative part lasting an average of 42 minutes (range 17-100 minutes).

Outcomes relating to Social Care Related Quality of Life (SCRQoL) were also measured quantitatively using the Adult Social Care Outcomes Toolkit (ASCOT) INT4 (see 3.4.4). Participants were asked to think specifically about centre attendance when rating their quality of life in eight domains. Scores were then calculated. Deducting expected SCRQoL scores (in the absence of day centre attendance where nothing took its place) from current SCRQoL scores resulted in SCRQoL gain scores which indicate the difference that centre attendance made to participants' lives. The higher the score, the bigger a positive difference centre attendance made to SCRQoL.

In the qualitative part of interviews, attenders were asked to talk about their outcomes and experiences. To discover whether centres made a unique contribution to attenders' lives, one question concerned whether attending a centre added anything to their life that they would not experience otherwise. Other outcomes were also discussed more generally. To establish which were their most valued outcomes or experiences, attenders were asked about the two things they liked best about going to a day centre. They were also asked about the two things they liked least and whether there was anything they would change. Their feelings about and experiences of attending were explored. These conversations covered finding out about centres, their preconceptions of them, first experiences, their views on the activities, co-attenders and those who provided the service, dealing with problems arising, getting involved in operation, payment, value for money and whether they planned to continue attending and would recommend attending to others in a similar situation.

The next section summarises the qualitative and quantitative data about outcomes, the unique contribution attendance made to participants' lives and what they liked best about attending.

8.2 Summary of attendance outcomes, its unique contribution and participants' favourite aspects

Table 12 summarises the qualitative and quantitative findings about outcomes experienced and participants' accounts of their favourite aspects of attendance and its unique contribution.

The nine themes arising concerned social interaction, the way time was spent, mental wellbeing and health, getting out of the house or having a change of environment, practical support, information and access to other services, physical wellbeing and safety, having a meal, accommodation cleanliness and comfort, and personal care. Certain aspects of attenders' experiences and outcomes contributed to a further theme of process outcomes.

Attending a day centre had added something unique to the lives of all but one attender. Some said it had added more than one thing to their lives. For one, it had not just 'added' something to her life, it had changed it. The participant who said that attending a centre did not add anything to her life later added that the cost of attending was worth the money as going there meant a change of environment.

Six of the eight ASCOT domains overlapped with the themes arising in the qualitative data. Three additional outcome themes beyond those identified by ASCOT emerged from the qualitative data: 1) getting out of the house (incorporating a change of environment), 2) an expanded theme of improved mental wellbeing and health and 3) accessing practical support, information and other services. The first two were among those reported as unique contributions of day centre attendance.

The domains of social participation and occupation mapped directly across to the themes of social interaction and activities, or the way people spent their time. As well as being two of the three highest scoring ASCOT domains, these were the most-named favourite aspects of attendance and unique contributions that centre attendance added to their lives.

The theme of 'mental wellbeing and health' encompassed not only dignity (personal sense of significance) and control - the second and third highest scoring domains of gain - but also the favourite aspect of feeling useful and the unique contributions of the 'opportunity to make a difference' and a sense of purpose, freedom, independence and being in control. Both dignity and control contributed to process outcomes as did another favourite aspect of attendance, the character and behaviour of the volunteers, staff and managers. However, the ASCOT domain is about 'control' in daily life whereas the scope of the qualitative theme is solely within the centre.

Despite also having a broader scope, personal safety, the third highest scoring domain of gain, has been incorporated within the theme of physical wellbeing and safety. The concept of safety refers to both feeling and being physically safe, and feeling safe emotionally. The latter is not considered by ASCOT but, here, falls within the overall theme of mental wellbeing and health.

Attendees' top three favourite things - social aspects, activities, and managers, staff or volunteers - arose in all four centres.

A further unique contribution and a favourite aspect of attendance was getting out of the house or having a change of environment, which also covered having a place to go. One person's favourite thing was the centre's garden.

Outcome themes not reflected by centres' unique contributions to people's lives were 1) physical wellbeing and safety, 2) practical support, information and access to other services either within or outside the centre and 3) having a meal. 'Having a meal', a favourite aspect of attendance, is narrower than the 'food and drink' ASCOT domain of gain which covers accessing adequate food and drink at appropriate times.

Finally, centre attendance was reported to make a difference to some people in the ASCOT domains of accommodation cleanliness and comfort and personal care, but there was only a small gain in the former and none in the latter. These were not represented in the qualitative outcome themes this study has identified. Two participants, however, implied that attendance did affect their personal cleanliness and comfort but this was not reflected in ASCOT scores because of their response decisions. One commented that attendance did affect how clean he felt, since he bathed and wore his best t-shirt on attendance days and the other took care of her appearance as she knew men would be present, but linked this with social interaction.

The next section covers the quantitative measurement of outcomes.

Table 12: Summary of findings about the outcomes of attendance, its unique contribution to attenders' lives and their favourite aspects of attending

Outcome themes (qualitative and quantitative)	QUALITATIVE FINDINGS				QUANTITATIVE FINDINGS (ASCOT)	
	Attenders reporting this outcome (n=23)	Attenders reporting this unique contribution to their lives (n=22)	Total no. of references within theme	Favourite aspects of attending (n=23)	Attenders responding that attendance made a difference to their lives in this domain (n=22)	SCRQoL gain (n=22)
Social interaction / participation/ companionship	21	11	247	20	19	Highest gain
Activities/changing way spent time	17	6	117	11	15 (occupation)	Joint second highest gain
Mental wellbeing & health	20: - enjoyment (n=18), laughter and fun (n=7) - sense of purpose (n=5) - sense of independence, freedom and control (n=3) - boredom/monotony kept at bay (n=5) - gained better perspective of own situation (n=4) - felt more relaxed (n=3), less lonely (n=3), less depressed (n=3), more confident (n=3), more mentally stimulated (n=3) and energised (n=1)	7: - 6 felt better - 2 an opportunity to make a difference - 2 feelings of freedom - 1 feelings of independence and control	187	1 feeling useful by helping volunteers and manager	11 (control over daily life)	Joint second highest gain: Dignity/personal sense of significance (not depicted in Figure 29) Joint third highest gain: Control over daily life
Getting out of house / change of environment	13 - getting out for a change of environment (n=10) - somewhere to go (n=3)	6	46	4 getting out of the house 1 the garden	NOT APPLICABLE	NOT APPLICABLE
Practical support, information & access to other services	18	-	47	-	NOT APPLICABLE	NOT APPLICABLE
Physical wellbeing, health & safety	9: - informal health and wellbeing monitoring (n=4) - increased exercise (n=4) - feeling physically safe (n=1)	-	21	-	12 (personal safety)	Joint third highest gain: Personal safety
Having a meal	3	-	5	4	10 (food and drink)	Fourth highest gain: Food and drink
Accommodation cleanliness and comfort	NOT APPLICABLE	-	-	-	7	Lowest gain
Personal care	NOT APPLICABLE	-	-	-	7	No gain
Process outcomes	3: sense of independence, freedom and control	1: feelings of independence & control		5 the character and behaviour of the staff, volunteers & (process outcome)	11 (control over daily life)	Joint second highest gain: Dignity/personal sense of significance –

8.3 Outcomes of attendance as measured quantitatively

The results of using the ASCOT INT4 tool with attenders to measure their SCRQoL are presented here.

Twenty-two of the 23 attenders completed ASCOT INT4. Overall average preference-weighted SCRQoL scores were 0.88 (current) and 0.70 (expected), with a resulting overall quality of life gain of 0.18 that was attributable to day centre attendance. The range of individual gain scores (0.00-0.62) suggests that some participants benefited more than others. Average gain was higher than the median (0.15) and the mode (0.05).

Due to the small sample, further analysis of gain scores by individual characteristics was not undertaken with two exceptions, namely day centre attended and funding type. Average gain varied between day centres (0.13, 0.15, 0.16, 0.24). In three centres, overall expected SCRQoL was 0.69 and 0.75 in the fourth. As a tool developed for users of publicly-funded services, which all centres were, average gain was calculated by funding type. Those with greater gain, of 0.23, were publicly-funded (n=6), with self-funders experiencing a gain of 0.15 (n=14); gain was 0.24 for the two who did not know they were funded. Gain was 0.24 for the combined group of publicly-funded attenders and those who were unsure of service funding source as they were likely to have been publicly-funded.

Current and expected SCRQoL are represented graphically, by domain, in Figure 29. SCRQoL scores are further broken down within domains in Figure 30 which shows unweighted scores as a percentage of the total possible score. These figures show that the highest gains were in the higher order domains. The greatest gain was in the domain of social participation and involvement. The next highest gain was in the two domains of occupation and dignity (personal sense of significance) which scored equally. Dignity is not depicted in the ASCOT radar diagram as an 'expected' level is not measured, and a population-based score used instead. To a lesser extent, gain was also felt with respect to control over daily life and personal safety, in which the gain was the same, and food and drink. There was minimal gain in accommodation cleanliness and comfort and none in personal cleanliness and comfort despite almost one-third of attenders saying that attending did make a difference to their personal care (see Table 12).

If centres were no longer attended and the service gap was not filled, the highest unmet needs would be in the domains of social participation and involvement and occupation, followed by a smaller scale of high needs around control, safety and food and drink (see Figure 30). Even when attending day centres, attenders have some high needs in the domain of social participation.

Figure 29: Social Care Related Quality of Life (unweighted) – attenders

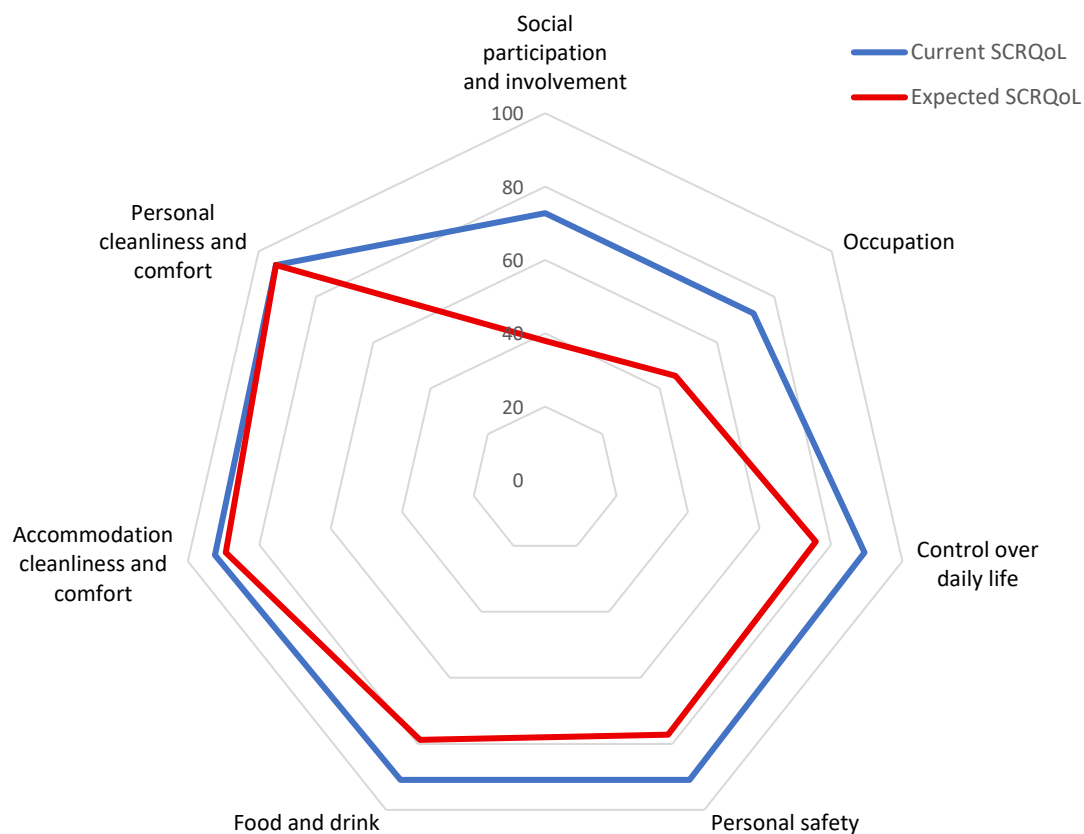
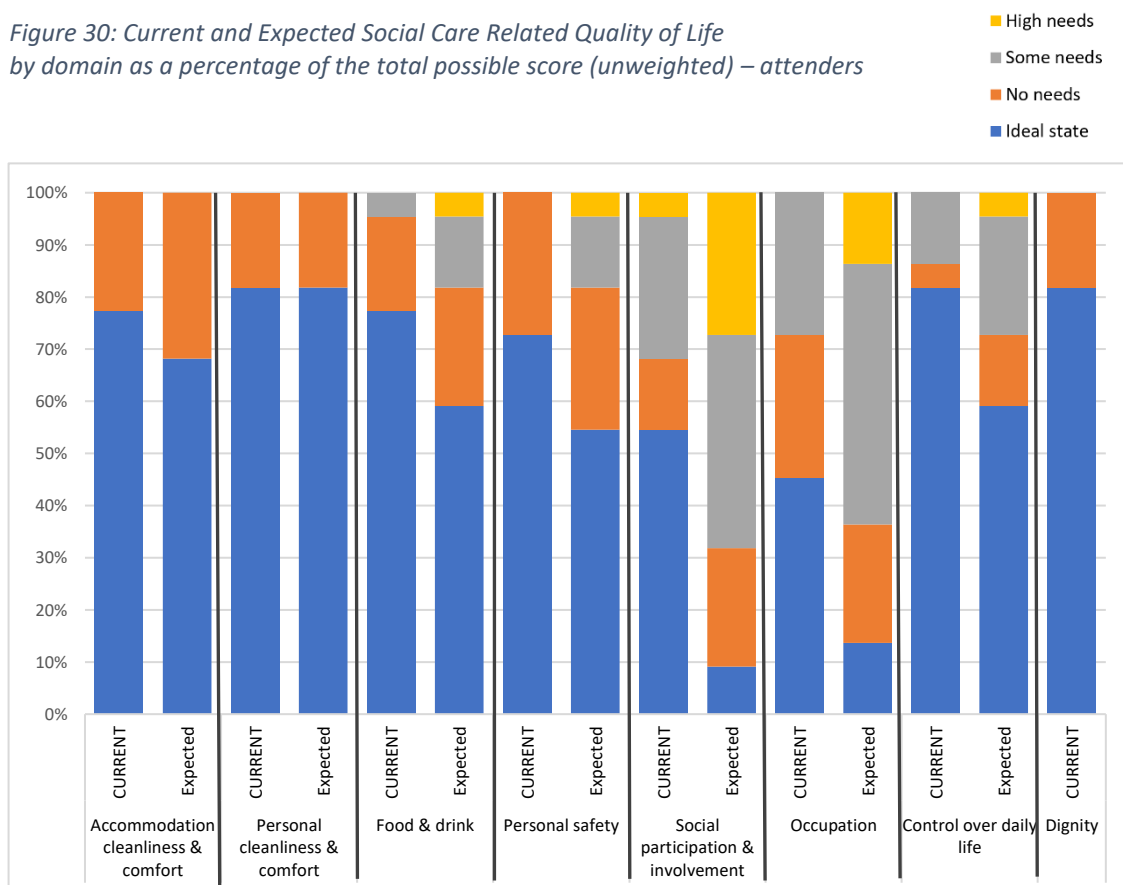


Figure 30: Current and Expected Social Care Related Quality of Life by domain as a percentage of the total possible score (unweighted) – attenders



The next section presents an analysis of the distribution of outcomes emerging from the qualitative data across attenders' individual characteristics and the day centres, and further detail on the qualitative outcomes.

8.4 Outcomes and experiences as reported qualitatively

This section draws on the qualitative data to elaborate on the seven outcome themes arising and experiences contributing to these: social interaction, activities, mental wellbeing and health, getting out of the house, practical support, information and access to other services, physical wellbeing and safety, and having a meal. After this, it presents experiences, some of which are also mentioned elsewhere, that are likely to have contributed to process outcomes, and other experiences. First, an analysis is presented of how the themes arising from the qualitative data were distributed across individual characteristics and day centres.

8.4.1 Outcomes across individual characteristics and day centres

Social interaction and mental wellbeing and health outcomes were gained by attenders across different marital statuses, ethnicities, age groups, genders, living arrangements, accommodation types, education levels, finances, number of days spent at the centre, number of operational days, EFS frailty levels, PANT network types, groupings⁹ of ASCOT gain and SWEMWB scores (metric).

The remaining three themes reported by more than half the participants emerged in most of the above characteristics sub-groups, with the following exceptions:

- activity-related outcomes: not experienced by participants with further education or with highest ASCOT gain score grouping (0.60-0.69);
- practical support, information or other services accessed: not experienced among married, five-day or attenders with four types of health conditions or disabilities;
- getting out of the house: not experienced by attenders with 'no frailty', according to the EFS, for those whose PANT network was on the borderline between family dependent and locally self-contained, for those aged 70-74, living with a family member other than spouse or adult child or in private rented accommodation, the single/never-married, those with further education or five-day attenders.

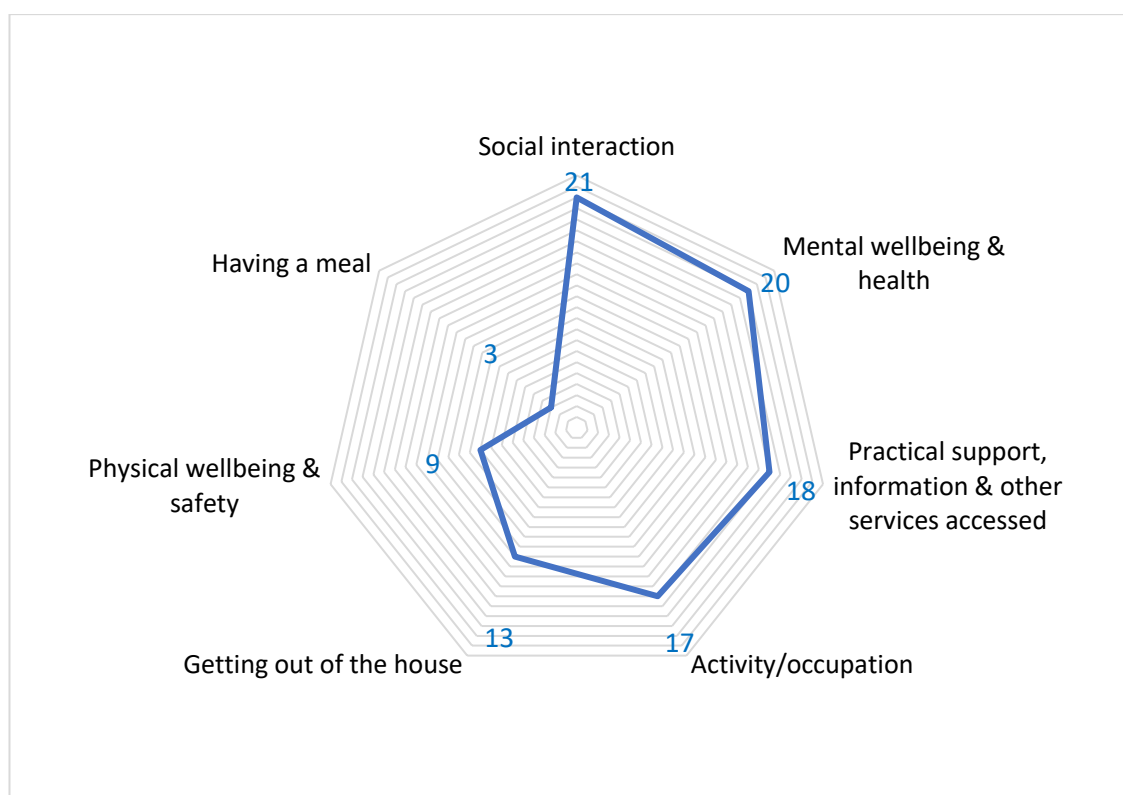
Physical wellbeing and safety and having a meal were outcomes gained by fewer than half the participants, therefore were not represented across all attribute types.

⁹ Score groupings were devised for this study as follows:
ASCOT: 0.00-0.09, 0.10-0.19, 0.20-0.29, 0.30-0.39, 0.40-0.49, 0.50-0.59 and 0.60-0.69.
SWEMWBs: 15.00-19.99, 20.00-25.99, 26.00-29.99 and 30.00-35.00.

All seven themes emerged among both self-funding and publicly-funded/unsure of funding source sub-groups. Although not a socio-demographic characteristic, funding type is included here since self-funders experienced lower ASCOT-measured SCRQoL gain compared with publicly funded attenders (see 8.3).

Figure 31 shows qualitative outcome themes across all four centres in a similar format to the ASCOT results (see Figure 29).

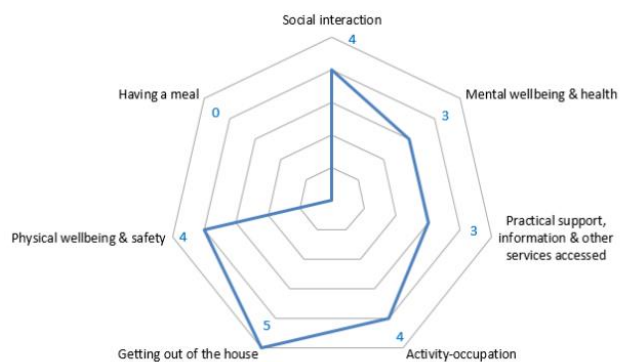
Figure 31: Radar diagram showing outcomes of attending day centres



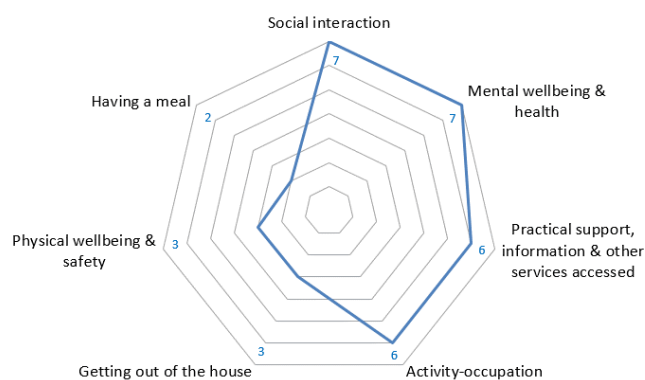
Although there are broad similarities in the patterns of outcome themes between the four day centres, Figure 32 also shows some noticeable differences. It is likely that these reflect the different characteristics of attenders at each centre, their different programmes of activity, and attenders' motivations for attendance.

Figure 32: Radar charts denoting outcome theme differences between the four day centres

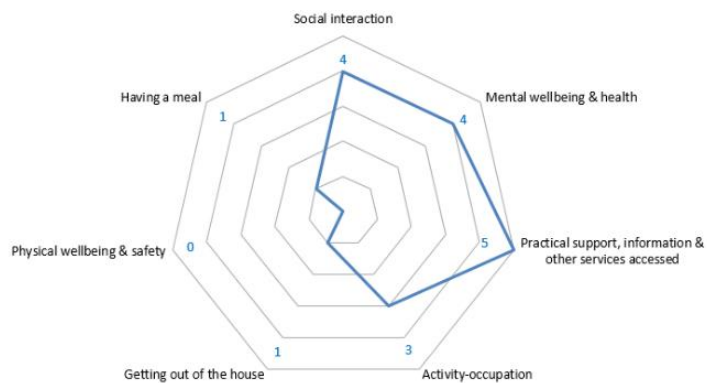
DCHA
(n=5)



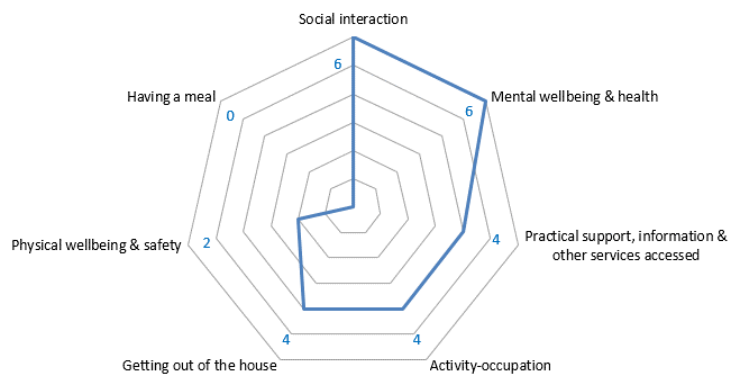
DCLA
(n=7)



DCV1
(n=5)



DCV2
(n=6)



8.4.2 Social interaction

Social interaction was a theme of extremes, perhaps well represented by the term 'companionship' which encompasses company during an experience and friendly relations, through to friendship (Collins 2017). The following extracts illustrate the levels of variation:

'I get conversation instead of talking to myself... And I'm mixing with human beings.' (Nellie)

'... they are good to talk to. There are one or two there that I don't talk to, but there are several that I do.' (Bob)

'We sit together and play together, like cards or any other games or ... the memory class, and of course, the exercise.' (Mariana)

'I don't like cliquey people. It's not like that there at all. Everybody is friendly with each other, which is lovely. (...) People tell each other quite intimate things as though you were a good friend of theirs.' (Kaye)

'You look forward to seeing friends again, you know.' (Elizabeth)

Attendance was said to address the problem of not meeting people when physically unable to get out of one's home, and social interaction sometimes started on the transport (bus) to the centre. Participants enjoyed mixing with older people or people in similar circumstances (n=5), with people who had different characters and interests (n=3) and chatting over lunch (n=2). Being with the same age group was felt to enable anything from the exchange of simple pleasantries to stimulating conversations – and disagreements - about subjects that mattered, and gave a feeling of belonging to a group. Some preferred to listen as conversation did not come easily which one participant speculated was *'because I've got so used to my own company'* (Olive). One participant captured the significance of having social contact when you are usually alone:

'It's like, if somebody is married and they are not happy in their marriage, they look for a way out. Well I am not happy being at home on my own and so that's my way out.' (Tina)

Being in a group was also an opportunity to have fun and a joke (n=6):

'I can have a mini joke or— [laughs] you can sit down and hear something very funny' (Thomasina).

*'I think that's one of the things that I like about it. You have heard [female attender] and I **roar** with laughter before now, haven't you? ...I can make her laugh so easily. I love it. I know when she laughed her head off one day when one of the questions was what did Richard II lose in the bushes and I called out, "his virginity." She said, "for God's sake." I don't know. I just like laughing anyhow.'* (Kaye)

Half the participants (n=12) were complimentary about their friendly and welcoming co-attenders who sometimes exchanged blown kisses; one fondly recounted stories about funny incidents. Some made observations about how people mixed (n=6) which, I had noticed, varied between centres and appeared to be partly influenced by room layouts and activity options. At one, regular seats and seat-saving were actively discouraged and attenders were flexible and happy to sit anywhere. Elsewhere, I saw attenders sit in the same place and usually with the same people for

lunch - although these two groups of people sometimes differed - and seat-saving behaviour that was both protective (e.g. pleasantly pointing out that a named attender liked or needed to sit there for a given reason) and aggressive (e.g. asking someone to move or prohibiting anyone from sitting in a seat). One participant felt that a choice to sit alone should be respected.

While a few did not get on with some co-attenders, others had made friends (n=7) or reconnected with people (n=4) known previously through clubs or events, family connections, living nearby or in the same building. Contact between attenders had not developed outside centres, which corresponded with participants' 'Maps of the Week' (see 7.6.3). Only one outside connection, with a manager, was reported to have developed; during fieldwork, their closeness was apparent and, in an interview, was referred to unfavourably by another attender. Exceptions were two attenders reported having had outside connections that had stopped due to reduced mobility or memory loss and another occasionally received telephone calls from the person she sat next to at the centre. Lack of outside contact was perhaps linked with one participants' view that the nature of 'friendship' changed with age, and because many (n=14) appeared to consider co-attenders as simply acquaintances whom one saw regularly at the centre anyway:

'They are just Friday people.' (Thomasina)

'It's not that I don't want to, it's just we've never got round to it, really. I suppose it's because I see them twice a week anyhow.' (Kaye)

Levels of connection made were also related to cognitive impairment. Eleven participants spoke about co-attenders' cognitive impairments. Comments covered memory loss, dementia and learning disabilities, but only a few referred to 'dementia'; a few appeared unaware that some of the people they were talking about, either positively or negatively, were cognitively impaired. Such impairment was said to affect the quality of conversations (n=1). One centre was said to have a whole table of people one could not converse with (n=1). Although one attender referred to a co-attender with dementia as *'a sweet little thing'* (Jenny) and was impressed how well she joined in with games, poor memory had hindered the development of friendship. Another concluded that she was not keen on her co-attenders was because *'you are talking to them and they are just looking at you'* (Olive).

Only two attenders found seeing cognitively impaired people sad, some were sympathetic to their needs, and others felt that their own needs were given lower priority because their centre had insufficient capacity to give the one-to-one attention this group needed. Some behaviour was said to be problematic (n=3), but attitudes varied. One attender accepted that *'We are all different. Some are a little outspoken and they don't mean it'* (Mariana) while another did not understand why some people disliked him, and a third said *'Some are a little bit annoying (...) One time she started smacking people with her stick'* (Elizabeth). Some co-attenders with learning disabilities

were said to be unproblematic and two were not commented upon; participants may have been unaware of their disability. Others were said to make conversational *faux pas* which needed explanation as to the reasons for their social unacceptability, be rather young for a day centre, constantly rock which was distracting, swear and make unintelligible burbling noises which *'would be frightening to some people'* (Francine) and, potentially, off-putting for newcomers, and exhibit 'odd' behaviour which was tolerated by the manager and volunteers although the repercussions of this behaviour were occasionally time-consuming for the service providers.

Three male participants did not comment on gender balance, but the only two at one centre said they would prefer higher numbers of men because men and women chat about different things. One woman enjoyed having male co-attenders which motivated her to take care of her appearance and gave more opportunities for banter and discussion since *'they very often have different opinions to us. It's nice to argue that out with someone'* (Kaye).

8.4.3 'Activities' or changing the way time was spent

'Activities', which referred mainly to organised activities but also encompassed the way time was spent in that attending the centre was, itself, an activity and meant doing something instead of doing nothing at home or that was *'just quite different to what you are doing at home'* (Kaye). It also gave attenders something to think about and they enjoyed being occupied:

'I just sit here [conservatory] from when I get up to the time I go to bed.' (Ruby)

'If I am at home I just either sleep or watch the box [TV] (...) I read, or do puzzles or do knitting, making blanket or something.' (Norma)

'I like to be doing something.' (Lenny)

'It's enriched my life (...) Well I suppose it gives me an interest, doesn't it? It's a big interest. And it gives me something other to talk about and to think about.' (Jenny).

Some reported enjoying structured and informal activities generally while others mentioned specific activities they particularly enjoyed or disliked (see Table 13). Almost half (n=12) said activities were both good and varied and they were happy with them. Certain activities were felt to keep attenders' minds active and stimulated (e.g. current affairs discussions, Scrabble). Activities included things some participants would not have chosen to do, but reported enjoying, and things they would have done in the past but were no longer able to do or organise and which, consequently, were satisfying:

'I'm very fond of animals... I used to have a dog and a cat but I can't look after a dog anymore.' (Francine)

'Oh yes, especially when we go on the boat. Oh, I love that, yes. I enjoy that... They take us to [town 25 miles away], the [name of river]. You have nice sandwiches and everything on board, and tea. The staff make you tea. Ever so good.' (Kenneth)

*'Yes, I **enjoy** the art. I **enjoy** the singing. I **love** to sing. I don't mind whether there is one or two singing.'* (Wilma)

Table 13: Activities particularly enjoyed and disliked

Type of activity	Activities	Key
		Plain text: Activities enjoyed Italics: <i>Activities disliked</i> Capitals: ACTIVITIES BOTH ENJOYED AND DISLIKED
Entertainment	Belly dance performers Folk dancers	Music sessions (sometimes interactive)
Visiting speakers	Interest topics (e.g. 1950s, different countries, family history) Useful talks (e.g. sensory loss, government benefits, taxi vouchers, a local person cooking meals to order, home security, Police Community Safety Officer on bank card and telephone fraud, alcohol awareness)	
Interactive visitor-led activities	EXERCISES Craft Food tasting	Poetry reading Therapy dogs
Activities led internally	BINGO EXERCISE QUIZZES <i>Card-making</i> Art and craft Charades Computer classes Cooking	Current affairs discussion group Memory exercise class Raffle/tombola Singing Sweet shop Trips out Twenty questions
Informal activities	PLAYING CARD GAMES Listening to background music in main day centre room Games (Scrabble, dominoes)	Reading newspaper Sitting in garden Using the computer

Four activities evoked mixed reactions. Dislikes of bingo, quizzes and exercises were due, respectively, to considering these unstimulating, too frequent and either too easy or painful. Brief bingo games were enthusiastically welcomed at one centre. One attender did not enjoy card games despite selecting it over other options. Another laughed while recounting how others' cognitive impairments affected her regular card playing experience:

'[Male attender] who does it, he's completely gone, you know (...). He will keep putting down what we get [scores] (...) he gets all in a muddle. Of course, it irritates [female attender] and then [volunteer] will join us (...) and she keeps shouting and wanting to talk to everyone in the middle of playing cards. So, of course, it gets up [female attender]'s nose, because she's not looking at her cards, she's talking to people and not playing the game.' (Jenny).

One attender disliked most activities on offer except bingo, something atypical hence not represented in Table 13, yet her views were contrary. She preferred to take her own knitting to the centre rather than join in the craft activities as she was *'not fond of making tissue paper flowers. (...) I haven't got the patience. (...) I can't have anything too fiddly'*, yet was thinking of asking the activity leader *'to show me how do a flower. They've done them here for our open day and they were really gorgeous'* (Olive). Throughout the interview, she compared her current and previous centres, perhaps because she had not chosen to leave her previous one which had changed its admission criteria leaving her no longer eligible to attend. While her previous centre reportedly had more varied activities, a co-attender said their current centre had more options

than her other one, but only on days the activity leader was present. One attender commented that different activities took place on days other than my visit day.

A few attenders empathised with activity planners given the challenges of mobility and age differences. Some attenders were pleased to have choice about whether to join in and did not feel pressured to. Some joined in with some activities but not all. Some tried but were unable to enjoy certain activities as much as they would have liked due to lack of compensation for hearing or sight impairments. Manager-organised special occasion parties were excellent, according to two attenders. One attender appreciated how attenders' art was on display. Changes for the worse, reported by a few attenders at different centres, included fewer options or less variety than previously, certain activities becoming shorter or stopping and the regular hairdresser no longer visiting:

*'I don't think it's as good as it was (...) Time just goes. We don't seem to get much **done** or **entertained**. We're **left**, if you know what I mean (..) Not so much seems to happen these days' (Ruby).*

8.4.4 Getting out of the house and a change of environment

Centre attendance enabled people to 'get out of' their house, something framed in two ways.

Firstly, it was tantamount to escaping from their home in which they felt they were stuck, or even a 'prisoner', thus offering a change of environment:

'Well, it gets me out of my four walls for a start.' (Nellie)

*'it's like being a prisoner in my house now, which it **is**. That's how it feels now and again, because you don't **see** nobody there now.'* (Olive)

*'Well, it gets me **out** once a week, which I wouldn't do otherwise.'* (Ruby)

Secondly, centres were somewhere to go when you had '*nowhere else to go*' (Nellie). They appeared to be a good substitute for what some may have preferred to do had their abilities been different. Attenders explained how travelling on public transport when one cannot walk well and finds stairs difficult meant that other types of outings were extremely hard, especially when also considering toilet availability. One attender commented that saying hello to an acquaintance in passing was '*not the same as actually going to a function **with** the people*' (Bob). Thus, centres were also a 'place' to go and to gather:

*'Maybe before if, like, I was able to travel and go here there and everywhere, which I used to do, I wouldn't want to stay at home. I used to like going here, there and everywhere. Now I can't **do** that so I don't mind coming here...I am happy with it...It gives me a chance to come out. (...) Like I said before, if I could go round and do things that I would like to do and so I'd go shopping and maybe walk around. Right now I'm stuck indoors.'* (Dorothy)

This change of scene offered a welcome garden in which to sit for one attender who was unable to access her own garden. Despite that this person's most valued outcome was getting out of the

house, her two days at the centre did not entirely satisfy her need to get out and her preference was to be taken out by somebody rather than have an extra centre day.

Five attenders commented on the day centre space and location. A rest room for people feeling unwell was considered useful. Co-location with a library was a 'bonus' for a keen reader who also enjoyed occasional contact with babies at the mother and baby group meeting there. For the third, the space itself was of no consequence; it *'could be a dust-hole. As long as the people are nice and you are happy there, what's the difference? It doesn't have to be Buckingham Palace'* (Tina). The fourth had not been put off attending at finding the centre *'a bit shabby'* (Wilma) but appreciated its beautiful decoration since then. For the fifth, the building compared poorly with her previous centre which had more small rooms meaning she now felt *'cooped up in one room'* (Olive). Regrettably, attenders interviewed did not include those attending the short mid-week service at a co-located church or the attender who had been using the co-located Citizen's Advice Bureau after a bereavement.

8.4.5 Practical support, information and other services

Practical support and services were offered from within the centres themselves as part of the day centre, by occasional or regular visitors, visiting professionals or speakers. Participants commented upon hearing aid maintenance (n=8), information or useful talks (n=6), a chiropodist (n=1), a masseuse (n=1), a clothes salesperson (n=2) and being visited by the district nurse (n=1). Staff helped with arranging appointments and provided hairdressing (n=1) and fingernail filing and painting (n=1). They also facilitated access to other things, for example, staff in one centre had helped an attender obtain a personal alarm and were discussing referring another to a chiropodist.

Attendees were also assisted to access other services operated by the centre provider or other organisations. Support that did not form part of the day centre explicitly included information about and support to claim taxi vouchers/card (n=3) and install a home personal alarm system (n=1) and services offered by a sensory loss support organisation. Attendees of one centre also accessed the provider's other services, namely holidays (n=4), shopping trips (n=3) and a monthly lunch club (n=1). One of its attenders felt lucky because she thought that few centres offered so many other services. The co-located library, church and CAB were referred to in 8.4.4.

Practical support, information and other services accessed had made a difference to seven attenders. Differences made were saving money (n=4) or having trips elsewhere (n=3), feeling safer or having peace of mind (n=2), having more money (n=1), being more aware about certain things (e.g. alcohol intake, home security) or feeling more settled at their centre after a group holiday (n=2).

8.4.6 Physical wellbeing and safety

Informal health monitoring included attenders being asked how they were or what was the matter, which they appreciated. Staff were reported to have been helpful by, for example, explaining GPs could do home visits, speaking to named relatives about any health concerns arising, measuring blood pressure, replacing a glasses screw, helping attenders feeling unwell to go to the rest room or listening to them talk about health matters, such as continence and pain. During fieldwork visits, I heard of an attender with a painful finger being advised by staff to speak to her daughter or GP about this, another who was visited in hospital by a staff member after being admitted suddenly and a third who had asked staff to report a safeguarding matter on her behalf.

Some attenders said exercise at centres helped maintain suppleness and alleviated depression. Two recognised that they were more likely to exercise in a group than at home, alone. One's referral to the centre after an operation was for this reason. Although one leg had improved, she was not sure whether the other had after ten years of exercising there, but believed it had maintained her mobility level. The other said:

'I think I quite enjoy it when there is people come and give us exercises and things, you know, make us to do things. (...) I think it's good for us. (...) I can sit here all day and not move. [Laughs] I could move, but I think it's good to make you do a few exercises. If you're all doing it, you do it.' (Ruby)

One attender, who fell due to vertigo, felt safer at the centre rather than home alone with her falls alarm. During fieldwork, another spoke about feeling vulnerable at home after an incident.

8.4.7 Having a meal

In this thesis, meals are categorised separately since people would be eating lunch at home on non-day centre days. The three attenders viewing the meal as an outcome included one who was unable to stand for long periods and whose lunch club had closed, another who wanted *'a meal put down in front of me without having to cook it myself'* (Isobel) and a third for whom the hot meal was a highlight of attending the centre.

Participants also shared their positive (n=17) and negative (n=2) views on meals. Some appreciated the quality of food and not having to cook. While, for some, these were good or very good (n=11), sometimes with a good range of choices (n=4), for others, they were alright (n=2) or of variable quality (n=2). One participant, who said she was 'bad' at eating, struggled to eat the meal despite enjoying the food. A few considered meals good value (n=2). Food presentation was good, according to one attender, and another appreciated conversation over lunch. Negative comments related to one centre. The first's comments concerned long waiting time, lukewarm food, being rushed and poor variety which was problematic since she was diabetic, had to eat regularly and she did not feel catered for. The second brought her own packed lunch, having disliked the meals

provided. Although commenting on their improved quality with a recent caterer change, she continued with a packed lunch as her diabetes and kidney problems meant she needed to take care with her diet.

8.4.8 Mental wellbeing and health

Enjoyment, which included laughing and having fun, was derived from social contact, the activities, getting out of the house, feelings of freedom, the meals and additional extras linked with a centre's location (e.g. library), transport to it and to attending a centre as an activity in itself. Enjoyment was an important mental wellbeing sub-theme that cut across centres, age groups, types of accommodation, education, finances, EFS frailty levels, ASCOT gain score groupings and PANT social network types. Exceptions were the two who lived with spouses, one of whom attended for five days.

The sense of purpose gained stemmed from having structure - *'something to wake up in the morning to do'* (Nellie) - and the opportunity to be helpful, contribute or share. Attenders offered others emotional and practical support by, for example, making suggestions based on experience (e.g. trying 'talking books' for the visually impaired), making people laugh, lending books, supporting fundraising by contributing items, buying or helping at sales or communicating funding opportunities, offering to help serve lunch or refreshments, and the 'active member' assisted volunteers practically. Taking in flowers from her garden fulfilled one attender's desire to share her love of nature. During fieldwork, two others took in flowers. Each time, flowers were placed, by staff, in small vases on lunch tables which provided conversation material. One attender mentioned having bought a goldfish for the centre's tank after another had died. Other examples, noted during fieldwork, included opening others' sauce packets at mealtimes, assisting with aprons, offering artistic suggestions when this seemed welcome, bringing in craft supplies known to be needed, and summoning assistance for attenders needing help.

The sense of independence, freedom and control gained resulted from being encouraged to choose how to spend time, having freedom to do things one enjoyed rather than having restricted options at home and an atmosphere in which one was offered choices (e.g. about meals) and being asked to pay for meals and refreshments received.

Attendance had also counteracted boredom and life's monotony, helped attenders gain a better perspective of their own situations and feel more relaxed, less lonely or depressed or more confident, mentally stimulated or energised. Attending had changed or enriched the lives of two participants and three said centres had been a 'lifeline'. Two attenders commented that the impact of centre attendance is also influenced by one's own mental attitude.

8.4.9 Process outcomes

While certain experiences contribute to the overall centre attending 'experience' (e.g. activities offered), others contribute towards 'process outcomes' which are those that *'pertain to the way services are accessed and delivered and may include feeling valued and respected, being treated as an individual, having a degree of control over the way a service is delivered, the degree to which a service fits with other support received and value for money'* (Qureshi et al. 1998).

The following five sub-sections consider the experiences contributing to process outcomes.

General contributors to process outcomes

Five factors combined to suggest that process outcomes were good for most attenders. These factors were attenders' overall positive feelings, that they planned to continue to attend and would recommend this to others, considered the centre to be good value for money and their views on the people providing the services. Each of these is now further detailed.

1) Overall positive feelings attenders reported were about going to their centres, in many cases since the first visit, despite some mixed feelings and a certain level of prior negative perceptions of day centres.

Atenders who looked forward to attending (n=14), loved going (n=9) or were happy to go (n=6)¹⁰ were spread across living arrangements, marital statuses, age groups, gender, education levels, number of days attended, ASCOT quality of life gain score groupings, PANT network types and EFS frailty levels. Feelings varied most among attenders of DCV1. Positivity, for three attenders, stemmed from attendance being a regular fixture, attendance providing a change of environment and, for one, knowing that her pain would be more bearable once there. However, most were more focused on the centres themselves, with different aspects of the general positivity of feeling summed up by the following four attenders:

'Well it's my life. It's all I've got. It literally is my life.' (Nellie)

*'I think it's the **best** thing they have done, [council], make this place (...). they do a wonderful job here. I don't think I'd rather be anywhere else but here. I really **do** enjoy being here (...) I am glad I come.'* (Isobel)

'All I can say is that, anyone who doesn't go there is missing out on something. I like it there and I think it's wonderful.' (Kathleen)

*'Oh, I **love** going. Oh yes. Yes.'* (Kenneth)

Four attenders were slightly less positive. One said she sometimes had to make herself go as it was good for her and she would miss it if she did not go. Another used to like going before so many people with dementia started to attend. The remaining two - one of whom was the only

¹⁰ Numbers do not total 23 as those who looked forward to it included attenders who were happy to attend; some said only that they looked forward to it.

participant to say that centre attendance did not add anything to her life - experienced mixed feelings and did not always want to go despite knowing they would enjoy it once there. Both highlighted the effort involved in getting ready and one her social awkwardness. The latter, despite reporting reluctance to attend, had already prepared her money for the coming week:

'See, I've already got my fiver for next, this is for next week. All my bits in there, coins I keep for the raffle. I'm all ready to go next week [laughs].'
(Jenny)

Prior to attendance, there had been a lack of awareness of day centres together with some negativity and some positivity towards them. Despite that all attenders had lived in their areas for at least a decade, only two had known of their current centre. The half (n=11) who had never heard of day centres spanned age groups, aged from 65-94 years. There was a mix of negative (n=6), positive (n=5) or neutral (n=1) views among the 12 who had heard of day centres, with some never having pictured themselves at one (n=5). Most attenders holding negative views were aged 84 years or older (n=5) and most attenders holding positive views were aged 83 years or younger (n=4). Of the positive-minded, three had experience through prior attendance of another centre, spousal attendance, volunteering activity or using a co-located service, one knew that day centres helped people and the remaining one, a 'joiner', saw them simply as places where older people gathered. Negative views stemmed from being told that '*funny people*' who needed to be fed or were '*really old*' attended day centres (especially off-putting when one did not feel old) (Francine), thinking they were like care homes or were for people of higher social classes, or they were simply mysterious. Three of those unable to picture themselves attending a day centre said they had never imagined they would be in their current situation; one in this group had felt positively towards day centres and two had not.

Although not all participants remembered their initial impressions of the centres, most reported these to be positive. Two thirds (n=15) recounted first visits that felt friendly and welcoming (n=11), that involved being greeted by the manager, staff or volunteers (n=10), being introduced to at least one other attender and shown where to sit (n=8) and being asked about their interests (n=1). One had been delighted to discover that the centre had her favourite board game.

The following two attenders were among six who remarked upon how quickly they had settled in:

'They were all very likeable people.' (Bob)
'...everybody took [to] me there as if I were there for a hundred years. They all like me.'
(Norma)

Although three women had been nervous beforehand and two men had found it a bit strange at the beginning, as they had known nobody and because '*when you go into a new club ... you don't know what, what it's going to be like...*' (Lenny), they were all pleased to have started attending. Nerves resulted from not having joined anything for so long, worry about offending family in the

case of disliking the centre or negative preconceptions. One had been relieved at the manager's acceptance of her depression and her supportiveness as she had been '*really getting rather desperate*' and had forced herself to attend even though '*it took a lot of courage to do it and to walk in*' (Ruth).

Conversely, two attenders had not found the centre friendly; one thought this may have been due to her own 'standoffishness' and the other to the, previously, cliquey environment. One had felt it seemed too quiet. Another had thought it rather shabby. Finally, one could not remember her initial impressions, but said that their centre had been better in the past, when she had first attended, because the group was larger and more able to have extended conversations as fewer were cognitively impaired.

2) All attenders planned to continue attending. While many were enthusiastic about doing so (n=16), one would continue simply because there was no other local option. Six recognised they might have to stop attending if their health declined, one of whom feared being put into a care home if she could no longer manage the stairs at home.

3) All attenders said they would recommend attending their centre to friends, family or somebody in the same situation as themselves. In some cases, this recommendation would be very strong (n=10), one because it was '*the only club that does all those things*' (Rosemary) (i.e. monthly coffee mornings, shopping trips and pub lunches). Four attenders had already recommended their centre to others.

4) Two thirds of participants (n=15), across the four centres, considered their centre offered good (n=12) or very good (n=3) value for money.

Of these, 11 fully or partly self-funded, three received full local authority funding and one was unsure how they paid. It is intriguing to note that a higher proportion of self-funders than publicly-funded attenders held this view given that Section 8.4 reported ASCOT gain scores to be lower among self-funders (see 8.4); perhaps contributing to this was that most of these self-funders attended DCV1 and DCV2 which had lower charges (n=9). One, a stoical, assessed self-funder, said '*whatever it is, you've got to pay for it*' (Olive) because the alternative was not spending the money and staying at home. Interestingly, this was the attender who disliked most activities and said that attendance added nothing to her life, just enabled a change of environment. Value was conceived in terms of number of hours received compared with cost by only one local authority funded attender. Despite saying she would not be able to afford to pay if not local authority supported, she considered the charge to be worth it particularly '*for people that are in wheelchairs or anything like that or stroke victims, I mean the help that they get from these carers is **amazing**. I*

*mean, they wouldn't have a carer coming in as **long** as they are at [day centre], you know. They're **there** all the time and then they can have a carer after or before. But I think it's really **good** for them'* (Francine). Rising costs were highlighted by four self-funders, who considered their centre to be good value, but these were '*not a **problem** (...) it's **well** worth it'* (Elizabeth).

Five of the remaining eight did not mention value for money. Of the other three, one considered the centre reasonable value for money but was unsure who paid for her attendance. The second, an assessed self-funder, said it was too expensive and not good value; if the charge was halved, she said she would have paid for a second day '*at least I would be out of here [her home] for two days, plus a carer coming another day. I should be alright'* (Thomasina). Finally, a local authority-funded attender considered that '*money doesn't come into it (...) If you are contented and you like the environment and the people you are with, what more do you want?*' (Tina). This, perhaps, was less of a grounded view since this attender did not know the cost of attendance and the centre she attended had reported a reduction in numbers following financial assessments, suggesting that cost did matter.

5) All participants shared, mainly complimentary, views of managers (n=11), staff (n=17) and volunteers (n=8), the focus of which, to a certain extent, reflected the varying staffing patterns.

Managers were said to be supportive, helpful, lovely and kind. They made time to speak to everyone despite their demanding job which they were good at and obviously cared about, offered solutions to problems, were pleasantly straight-talking, always cheerful, lively, happy to be teased and gave the occasional kiss. Other staff were most commonly described as friendly, helpful, wonderful, kind, caring, approachable and good listeners and understanding of people's problems. Having staff and managers who smiled and were happy to have a laugh made for a better experience. Staff's manner when encouraging attenders to join in activities was good and they managed rudeness and health crises well. Three attenders enjoyed spending time talking to or playing games with staff, but were often interrupted by others' toileting needs prompting them to suggest that more staff may be needed. Two attenders liked having a named key staff member and one appreciated that hers helped her with paperwork as she was unable to read. Two expressed sadness that a staff member they particularly liked had left (towards the end of the fieldwork).

Volunteers were most often said to be wonderful, lovely, helpful and kind. They looked after attenders well and were patient, friendly, clearly enjoyed what they did and always busy. One attender was fond of a volunteer with a learning disability, referring to her as a '*sweetie*' (Jenny) who always welcomed and hugged the attender; she also commented that the volunteer

sometimes lost her temper. During fieldwork, I witnessed personality clashes between this and another volunteer with a learning disability, which sometimes had to be curtailed by the manager, and with an attender with a learning disability. Attenders there appeared to be used to seeing the other volunteer stamping away apparently crossly. One attender said her centre needed more volunteers. Another was full of praise but was unclear whether people were staff or volunteers, referring to them all as 'carers'.

Less positively, one manager was thought to be a little bossy and not to fully understand sight loss. The only two criticisms of staff related to staff not dealing with attenders exhibiting unpleasant or disruptive behaviour and staff occasionally being a bit domineering. Three did not dislike, but were less enthusiastic about one staff member. Her loud voice meant it felt like she was shouting, she was less patient than other staff, was '*a bit prickly*' (Wilma) and made unwelcome comments about being called 'darling' by this attender. One attender did not feel the same connection she felt with other staff. During fieldwork, some attenders had grumbled quietly and rolled their eyes in response to this staff member. Her voice might have been appreciated by hearing-impaired attenders at other centres who had frustrations about not hearing what was being said.

This sub-section has covered overall feelings about day centres that are generally relevant to process outcomes. The next four sub-sections relate to the more specific experiences linked with feelings of control, being treated as an individual, feeling valued and respected and the fit of centre attendance with other support received, if any.

Having a degree of control over service delivery

The limited operational days of DCVA and DCV2 restricted choice of attendance day(s). Choice of days or number of days was more relevant to the referrals-only centres operating for five days, DCLA and DCHA. Only six of their twelve attenders talked about choice; four had chosen on which days or the number of days to attend and two had requested additional days but had been refused. Of the participants supported by social workers (n=7), three of whom attended the open access centres, four had not been offered choices of centre or other services and one did not say whether options were offered. Centres had either been recommended, were a second choice when the first was unavailable, or appeared on lists sent by social services after an enquiry.

Attenders mainly reported feeling in control of what happened while at their centres. They chose where to sit, which activities to join in reportedly without feeling pressured and what hot drink or meal to have. Although there was no choice of meals in one centre, attenders could choose whether to have the meal provided. During my visits, I heard an attender being offered an alternative from a local supermarket. At another, there was a choice of main meal but not dessert.

One attender felt the way she was treated by staff made her feel in control and more independent which had changed her life.

There was low awareness of, and interest in, opportunities to give feedback or to get involved in day centre operation, such as meetings or suggestion boxes. However, meetings were reported to gather some attenders' points of view.

All attenders answered without hesitation when asked if they would know what to do if unhappy with something at the day centre and if they would be comfortable raising concerns. Responses suggested that many felt safe or assertive enough to raise problems and had confidence in the centre managers (n=15). One felt it was her responsibility to raise concerns '*because if I think it's wrong for me, it must be wrong for others*' (Isobel). A small number, however, did not feel comfortable raising problems (n=5) or said they would simply stop attending the centre rather than address concerns (n=3). Reasons for reluctance included feeling the manager had '*enough on her plate*' (Jenny), worry that a complaint might not be welcome and not wanting co-attenders to feel embarrassed if their names were associated with a complaint. Fourteen said they would take concerns to the manager, and three to their named key worker. Three reported having previously brought up concerns with the manager and being satisfied that they had been listened to, a further three said that nothing to complain about had arisen thus far and one had previously kept something to herself.

Attenders experienced a SCRQoL gain in the control domain of ASCOT which is also relevant to this outcome (see 8.4).

Being treated as an individual

Certain experiences could contribute to both individual treatment and feeling valued and respected. Individual assessment or meetings at the start of attendance at one centre discovered likes and preferences, and around one third of attenders were also introduced to another attender, some of whom had continued to sit with that person. Having an allocated key staff member, at two centres, was valued. Experiences of transport (covered in 8.5.2) suggest that, in the main, attenders' needs were addressed in ways appropriate for each person. Individual preferences were also reported as being catered for in craft and singing activities. One attender received health care services at their centre, something this centre arranged according to individual needs. At all centres, staff and volunteers also monitored attenders' health and

wellbeing on an individual basis by enquiring how they were and following up where necessary. During fieldwork, I noticed the care taken to ensure that two attenders' food dislikes were catered for and how one centre was more successful than another at serving small meals to those who had expressed a wish for these. Only one attender felt she lacked the freedom to sit where she wanted because a rigid timetable of seating locations was operated. Thus, her control was limited and she was not treated as an individual.

Feeling valued and respected

Although attenders did not directly mention feeling valued and respected, this was implied by widespread positive reported experiences of staff, volunteers and managers and because their behaviour and character was one of attenders' favourite things about their centres. For example, attenders were greeted on arrival, enabled to make activity and meal choices, and their health and wellbeing were enquired about. Even busy managers were said to make time to speak to attenders. Good relationships with centre workers at all levels meant feeling comfortable bringing up personal or health problems. That some attenders spoke about their own contributions (e.g. flowers for lunch tables, fundraising contributions, support to other attenders) suggested they felt these were valued by workers or other attenders. Three examples demonstrate the respectful and empowering behaviour of staff and volunteers. During my visits, I noticed that attenders at one centre were asked their refreshment preferences before being served tea or coffee to give them choice despite these being displayed in the kitchen. In addition to showing respect for attenders' preferences, this also demonstrated individual treatment and enabled attenders to control the refreshments they received. At all centres, staff and volunteers empowered attenders to pay for lunch and refreshments by handing them their purse, assisting them to count money or counting it in front of them and checking they were happy with this. During my visits, I saw a staff member in one centre teach an attender how to use Facebook on a tablet computer by supporting her to carry out instructions. Conversely, some attenders also reported their sight and hearing impairments not being adequately addressed or reported feelings that attenders with special needs of some kind were being given preferential treatment.

Atenders' high SCRQoL gain in the dignity domain of ASCOT is also relevant to this outcome.

Fit with other support received

This study mapped attenders' usual weeks (see 7.6.3), offering some insight into attenders' lives outside their day centres. That interviews found that centre attendance made a unique contribution to almost all attenders' lives suggests that any other informal and formal support received did not meet all their needs or preferences. However, interviews with attenders offered no great insights into the way in which centre attendance was considered to formally support or

complement other support or services received, although many repeatedly referred to being alone at home. Only two attenders referred to their days of attendance in relation to other formal support or needs. Nevertheless, some of the initial assessments by centres were said to discover other formal support received by attenders (such as personal care) and it is possible that regular reviews undertaken with attenders may also have covered this, but this study did not have permission to access this data.

8.5 Other experiences

The following findings supplement the section on process outcomes by synthesising experiences beyond those already covered that were relevant to the outcome themes or to process outcomes (see 8.4). It first outlines attenders' reports of finding out about their centres and paying for attendance. Next, it sets out their experience of transport to and from the centre and their concerns about decreasing attender numbers. Next, two cross-cutting themes, age-related health matters and continuity of experience, are highlighted. Finally, attenders' least favourite aspects of attendance and suggestions for change are outlined.

8.5.1 Finding out about centres

Almost half (n=11) reported starting to attend following contact with social care or health professionals (social workers=7, district nurse=1, hospital rehabilitation service=1). The tenth was unsure of the professional's identity and the eleventh had spoken to a GP, then a social worker with whom attendance had been arranged by a family member. Two had proactively approached social workers about centres. Six had found out about centres from family (n=4), from its manager, an acquaintance, (n=1) and by co-attender recommendation (n=1). Some paths were less straightforward. Two had been told by a local councillor and a GP, and had subsequently had social work involvement. The former received a social worker assessment after starting to attend. The latter, after a 'bad' first experience at another centre she had been referred to by her GP, and asking family to find an alternative centre, the local authority home help linked them with a social worker who arranged a place in the current centre. Four participants were unsure how they found out about their centres.

Six attenders did not act immediately after finding out about centres, more so attenders of open access centres. One was unable to explain their delay, but others attributed it to reduced confidence, being shy, not wanting to go to a day centre, stubbornness and having negative preconceptions of day centres. Two had eased themselves in by attending an event organised by the centre provider.

8.5.2 Payment

The largest group were self-funders (n=14). These were people whose financial assessment, after being assessed as eligible for services, meant they had to pay (n=3) and people not mentioning any assessment (n=11). Others reported being fully local authority (means tested) funded (n=6), sharing payment with the local authority (n=1) and being unaware of who paid (n=2). None in the local authority funded group held a Direct Payment or mentioned being aware of being allocated a personal budget. One self-funder was not involved in payment as bills and payments were handled by a family member. Of the eleven mentioning being actively involved in payment, two paid with cash given to them by family members managing their finances and two paid the local authority invoices received. Three centres charged for lunch and refreshments separately, but only seven of their 17 attenders mentioned this. Local authority-funded attenders not involved in payment of the attendance charge may not have felt the need to be since they were involved in the more immediate payments for their meals and refreshments.

A few attenders assessed as having eligible social care needs made interesting points. One knew that local authority system changes meant attenders now needed financial assessments and paid according to their means. Being assessed as a self-funder meant it was financially viable for another to attend for only one day rather than the two days allocated. Another did not understand why non-attended days were charged-for, guessing this may be because a place cannot be allocated to another person because everything is pre-paid. Finally, one did not understand why she could not attend an additional day, beyond those the local authority paid for, at the reduced drop-in charge; any additional days would have been charged at the full rate because she had been assessed as having eligible needs.

8.5.3 Transport

Most attenders travelling to and from centres on provider-organised transport appreciated its door-to-door nature (n=18) and were happy with their journey, although two classed it as 'alright'. Drivers and/or escorts were friendly and helpful and knew attenders well, helping them from their front doors, assisting with wheelchairs and walkers, locking front doors or telephoning people when they arrived so attenders could wait inside. Journey time was said to vary considerably, from 10 minutes to an hour (n=6); 45 minutes was regarded as reasonable (n=3). Journeys were sometimes negatively affected by bumpy roads and traffic (n=3). The journey was quick for two attenders using the same volunteer car scheme; one missed driving and enjoyed the car run through the countryside notwithstanding - as both had commented during fieldwork - the slightly worrying speed. For some, journeys extended the social time, there being a pleasant, chatty atmosphere (n=3) and joking and laughing with the driver and co-attenders (n=3), however two commented that not everyone always said 'good morning' which meant that a visually-impaired

attender did not know who was travelling. Good transport reliability (n=4) and occasional lateness (n=3) were commented upon with respect to lateness causing worry, people not being ready or being slow walkers and it being irritating having to wait on the bus. Lateness was said not to be the driver's fault, but, nevertheless, shortened the time at centres.

A few attenders travelled in community transport, taxis or were driven by a family member (n=4). Three had started using taxis, paying with taxi vouchers (subsidised transport for disabled people from the local authority), after moving outside the area covered by the transport scheme, because the minibus was *'such a long journey, going round picking up people. Some aren't ready...'* (Rosemary) and because it took so long as well as being an uncomfortable *'boneshaker'* (Jenny) despite enjoying the minibus' scenic route. Two of them combined taxis with being driven by a family member in the morning and travelling home on community transport. The fourth booked her own community transport as she wanted to arrive and leave at her chosen times.

Finally, one active, relatively young attender walked to the centre: *'I'm very independent (...) while I've got a pair of legs I might as well use it'* (Lenny).

Payment for transport was mentioned by six attenders, who said they paid for their transport (n=2) or that it was free of charge (n=3). One did not know how it was paid for.

8.5.4 Falling numbers of attenders

Eleven attenders observed that numbers had dropped. Some said this had been relatively recent, although without explaining what they meant by recent. This change was attributed to people being unwell, having died or moved to care homes, the existence of a maximum limit, attendance now being chargeable or linked with managerial changes over the previous two years. Nobody suggested that it may be because people did not enjoy attending. One focused on how quiet it felt with fewer people, saying there would be a greater choice of people to chat with if more attended. Several were concerned that this fall in numbers may place their centre at risk, but thought there was a waiting list through which numbers could be built up. Interestingly one person holding this view had not previously heard of day centres:

*'I don't want to lose it. But I think there is a waiting list...I would imagine there is always a waiting list for these things (...) I'd certainly miss it if anything happened to it, and I think the **others** would'* (Ruby).

8.5.5 Cross-cutting theme: age-related health matters

Both attenders' own and other attenders' age-related health matters arose across day centres, outcomes and experiences. Their own sensory impairments impacted on ability to enjoy or join in certain activities, although one said their deafness was not problematic. One visually-impaired attender did not chat on the minibus as she was unaware of who else was there. Getting ready in

the morning was challenging; some were not ready when transport arrived. Some experienced fatigue during the day or afterwards. There was acknowledgement that activities needed to be appropriate to physical needs and mental abilities. That attenders were ill, had moved to care homes or had died was upsetting but could be expected and, occasionally, attenders experienced health crises at centres. Physical abilities also meant that staff needed to leave the floor to help with individual toileting. Seeing people with dementia, for a few, was sad. On a more positive note, seeing others who were worse off helped some by giving them a better perspective on their own situation.

8.5.6 Cross-cutting theme: the value of continuity

The value of continuity was another recurring theme. Continuity of people provided the opportunity to build relationships with co-attenders and those providing the service. Familiar faces (and seats) were welcomed; familiarity with voices was helpful for a visually-impaired attender. Many attenders looked forward to their visits; this regular fixture helped one attender after bereavement. Trusting relationships with staff, volunteers and managers facilitated the monitoring of attenders' health and wellbeing and made it easier for attenders to confide problems; providers knew and understood attenders' circumstances and why they were attending. Drivers knew names and individual needs. One attender attributed managing to build up his confidence to the point at which he could publicly thank the volunteer chefs to having got to know his co-attenders. As a vulnerable person, having confidence was important for him *'because there may be a day or something I have to stand up quickly, call for help'* (Lenny). Another inferred that being at an event with people enabled him to get beyond the 'hello' stage and facilitated companionship.

Continuity of company may have contributed to a sense of community. Although not arising during interviews, during fieldwork, the sense that centres were a community to which attenders felt they belonged was evident in that there was manifest concern about the welfare of any absentees. When once attender died, flowers were displayed and there was an air of sadness as staff circulated informing attenders individually. When discussing social connections in interviews, many talked about former day centre friends or acquaintances who had died or become ill and no longer attended.

8.5.7 Attenders' least favourite things about centres and their suggestions for change

Two thirds of participants (n=15) were adamant there was nothing they did not like, even after prompting about specific things mentioned earlier in the interview or during fieldwork. The consideration given to this question before answering and the conviction of responses suggested attenders did not feel pressurised into false positivity. One, who said there was nothing she liked

least, considered what she had said she was unhappy with as '*a little blip*' which would pass (Ruby). Three interviewees specified two things they liked least and five only one. Interaction with people with dementia (n=3) and lateness of transport (n=3) were the most common. Quality of conversation with people with dementia was poor and an aggressive reaction during a game had been taken personally, upsetting one person. Lateness of transport concerned a volunteer car driver's persistent lateness, people not being ready on time and a person with dementia who was, reportedly, confused about whether they had arrived at their final destination which caused difficulties at every pick-up. Given the attenders citing this problem, those not ready were likely to have forgotten what day it was. The day was thought too long for one attender but too short for another. Food was not always good (n=1), sometimes it was too quiet (n=1) and the room layout was constraining (n=1).

When asked specifically if there was anything they would change about the day centre, only a small number of attenders (n=4) said they would not change anything about the centre, despite one being irritated by an attender with a learning disability who rocked all day. Table 14 shows the suggestions for changes (n=10) were a mix of suggestions for extensions to the service or more of certain activities. The latter may indicate very low levels of dissatisfaction with current activities offered. That only two people's change suggestions were criticisms of staff and meals implies that almost all attenders were content with these, particularly given that staff featured among their favourite aspects of attendance and a high proportion spoke positively of meals.

Table 14: Attenders' suggestions for change

Positive suggestions	<ul style="list-style-type: none"> • Operational day longer at end of day by 30 minutes, one and a half hours or two and a half hours (n=3). They knew this was unrealistic. • An additional operational day (n=1). Attender knew funding meant this was unrealistic. • Introduce a toenail cutting service (n=1) to save a journey. • Introduce a sweet shop and raffles (n=1), partly to help with fundraising for trips out (n=1). • Day centre needs more volunteers, more attenders and more funding (n=1). • Changes to activities (n=2): more frequent board and card games, regular baking, more options of parallel activities in small groups taking place in different rooms.
Negative suggestions	<ul style="list-style-type: none"> • Operational day could be shorter by 30 minutes or an hour (n=2). Both attended once weekly and ascribed their lack of stamina to advanced age (mid-80s). • Staff: could be less pushy (n=1). • Meals: could be less rushed (n=1) • Transport: could be free (n=1).

8.6 Outcomes for older attenders as perceived by family carers and day centre volunteers and staff

Although one carer did not know what his family member gained from day centre attendance, most family carers and centre volunteers and staff perceptions of outcomes gained by attenders matched attenders' accounts of these in that perceived benefits related to social interaction, activities undertaken at centres and having a change in environment (see Table 15). These participant groups perceived a broad range of mental wellbeing benefits, including feelings of independence, control, self-esteem, purpose and stimulation, enjoyment, improved mood and having something to look forward to. Staff also highlighted feelings of emotional safety within the supportive environment they perceived day centres provided. Volunteers and staff placed more importance on the meal than did attenders. Exercise was perceived, by carers and staff, as a benefit. Staff believed that attenders felt physically safe and benefited from having someone to speak to about their health and wellbeing. That centres provided practical support and information was recognised by some staff. Additional volunteer perspectives were that centre attendance was a lifeline and enabled attenders to remain at home.

Table 15: Outcomes for attenders as perceived by family carers and day centre volunteers and staff

Outcome themes	Perceptions of outcomes gained by attenders		
	Carers (n=10)	Centre volunteers (n=7)	Centre staff (n=10)
Social interaction	7	7	10
Activities / something to do	See mental wellbeing and health below	3	7
Change of environment / getting out	2: Change of environment	3	2
Having a meal	-	5	5
Mental wellbeing and health	4 - Feelings of independence and control (3) - Feelings of improved self-esteem and purpose (3) - Less depressed (1) (feeling mentally stimulated by social contact and being involved in activities in a different environment)	3: Something to look forward to 1: Fun	3: Something to look forward to 4: Enjoyment 3: Improved mood/wellbeing 2: Purpose/structure/opportunity to contribute 3: Feeling safe / supportive environment
Physical wellbeing and safety	1: May prevent further physical decline	-	2: Exercise and feeling physically safe 5: Health and wellbeing monitoring / someone to talk to
Practical support, information and other services	-	-	4
Other	1: Attender seemed to view the centre as their main home	1: Lifeline 1: Enabled to remain at home	-

8.7 Summary

This chapter has reported the outcomes of day centre attendance and the experiences contributing to these. Outcomes addressed attender-related motivations for starting to use a day centre. Centre attendance contributed something unique to most attenders' lives. It provided social interaction, a changed environment, somewhere to go and different ways to spend time which, together, improved their mental wellbeing. Beyond these unique contributions, attendance also provided practical support, information and access to other services, a meal and contributed to physical wellbeing or feelings of safety. Most outcome categories were reported across socio-demographic and health characteristics, social network types and day centres. When measured quantitatively, outcome gain areas reflected some of those reported qualitatively. However, the quantitative measure did not reflect all outcomes emerging from the qualitative data. Two additional outcome themes arose, namely getting out of the house (incorporating a change of environment) and being provided with practical support, information and access to other services. Furthermore, the qualitative data suggested an expanded theme of improved mental wellbeing and health, a major sub-theme of which was enjoyment. The most-named two things attenders reported liking best about going to a day centre were two of the highest scoring, when measuring outcomes using the quantitative tool: the social aspects and the activities. Others related to the caring nature and behaviour of those working in day centres, the meal, the change of environment and having a purpose.

Attenders' own and co-attenders' age-related health problems impacted negatively on their experiences and outcomes, whereas continuity impacted positively and appeared to lead to a sense of community.

Reported experiences indicated that attenders experienced mainly positive process outcomes. It is likely that less positive feelings, a judgement that attendance may not have been such good value for money and, perhaps, fewer attenders planning to continue attending may be been more apparent had attenders not found themselves feeling valued, respected, treated as an individual or with a degree of control over service delivery. There was a lack of evidence about whether attendance had been considered in isolation or whether it had been planned around other support received, if any. This, perhaps, resulted from the study not having access to records documenting the process of attendance.

Although one carer did not know what his family member gained from day centre attendance, most family carers' and centre volunteers' and staff's perceptions of outcomes gained by attenders matched attenders' accounts of these.

Chapter 9 The outcomes for family carers, day centre staff and volunteers

Motivations for day centre attendance, attender characteristics and their experiences and outcomes were presented in Chapters 7 and 8. The present chapter is concerned with two other participant groups, carers (family members) of attenders and day centre volunteers and staff, addressing the remaining elements of research question three (underlined):

3. What are the outcomes of day centre attendance for older people, their carers, and volunteers, and of staff working at them?

This chapter presents the findings from interviews with these individual participants within the case study sites to help answer this question. As explained in 3.5.3, findings for each participant group are presented together rather than being analysed by each centre due to small sample sizes and consequent problems for conclusion-drawing and compromising anonymity.

Findings in respect of carers appear in Part 1 and centre volunteers and staff in Part 2, both of which start by outlining the approaches taken to data collection and summarising participant characteristics. Subsequently, Part 1 reports outcomes as measured quantitatively and reported qualitatively by carers, under themes raised in the data analysis, and presents process outcomes experienced. This is followed by their suggestions for improving what is offered by day centres. It ends by relating what outcomes carers perceived their relatives to gain from day centre attendance. Part 2 reports participants' characteristics, the outcomes of volunteering and working at day centres and their feelings about day centres. Findings are summarised at the end of each Part.

PART 1: FAMILY CARERS OF DAY CENTRE ATTENDERS

After opening with an outline of the approach taken to gathering data, this part summarises the characteristics of the overall family carer sample participating in this study. Next, both qualitative and quantitative data concerning outcomes and carers' most valued outcomes are summarised in tabular form with an accompanying commentary. After this, the findings of quantitative measurement of outcomes are presented. The following section provides further detail on the five outcome themes identified in the qualitative data and presents experiences likely to have contributed to process outcomes. After this, carers' suggestions for change are set out. Finally, attenders' perceptions of the impact of their centre attendance on family carers are set out, before findings are summarised. Managers' and local authority employees' perceptions of outcomes gained by carers were set out in Chapter 6.

9.1 Approach to gathering data

Mixed methods in face-to-face interviews with carers (defined in 1.5.3) gathered data about outcomes of a family member's day centre attendance. Data about carers' views were gathered qualitatively in interviews. On average, full participant interviews lasted 59 minutes (range 28-92 minutes), with the qualitative part lasting an average of 11 minutes (range 10-34 minutes).

Outcomes relating to Social Care Related Quality of Life (SCRQoL) were also measured quantitatively using the Adult Social Care Outcomes Toolkit (ASCOT) INT4 Carers (see 3.4.4). Carers were asked to think specifically about day centre attendance when rating their quality of life in seven domains. Scores were then calculated. Deducting expected SCRQoL scores (in the absence of day centre attendance by the older person where nothing took its place) from current SCRQoL scores resulted in SCRQoL gain scores which indicate the difference that centre attendance by a family member made to carer participants' lives. The higher the gain score, the bigger the positive effect of the service on a carer's SCRQoL.

In the qualitative part of interviews, carers were asked to talk about any outcomes they had gained from their family member attending a day centre and whether they had been given any information, got involved in any activities or used any other services as a result of their relative attending the centre. To establish the most important outcomes for them, they were asked what they valued most about their relative's centre attendance. Their feelings about day centres were then explored. These conversations covered whether they felt centres represented good value for

money, if there was anything they would like to change about centres to make them better for them as carers, whether they planned for their family member to continue using the centre and whether they would recommend its use to other carers.

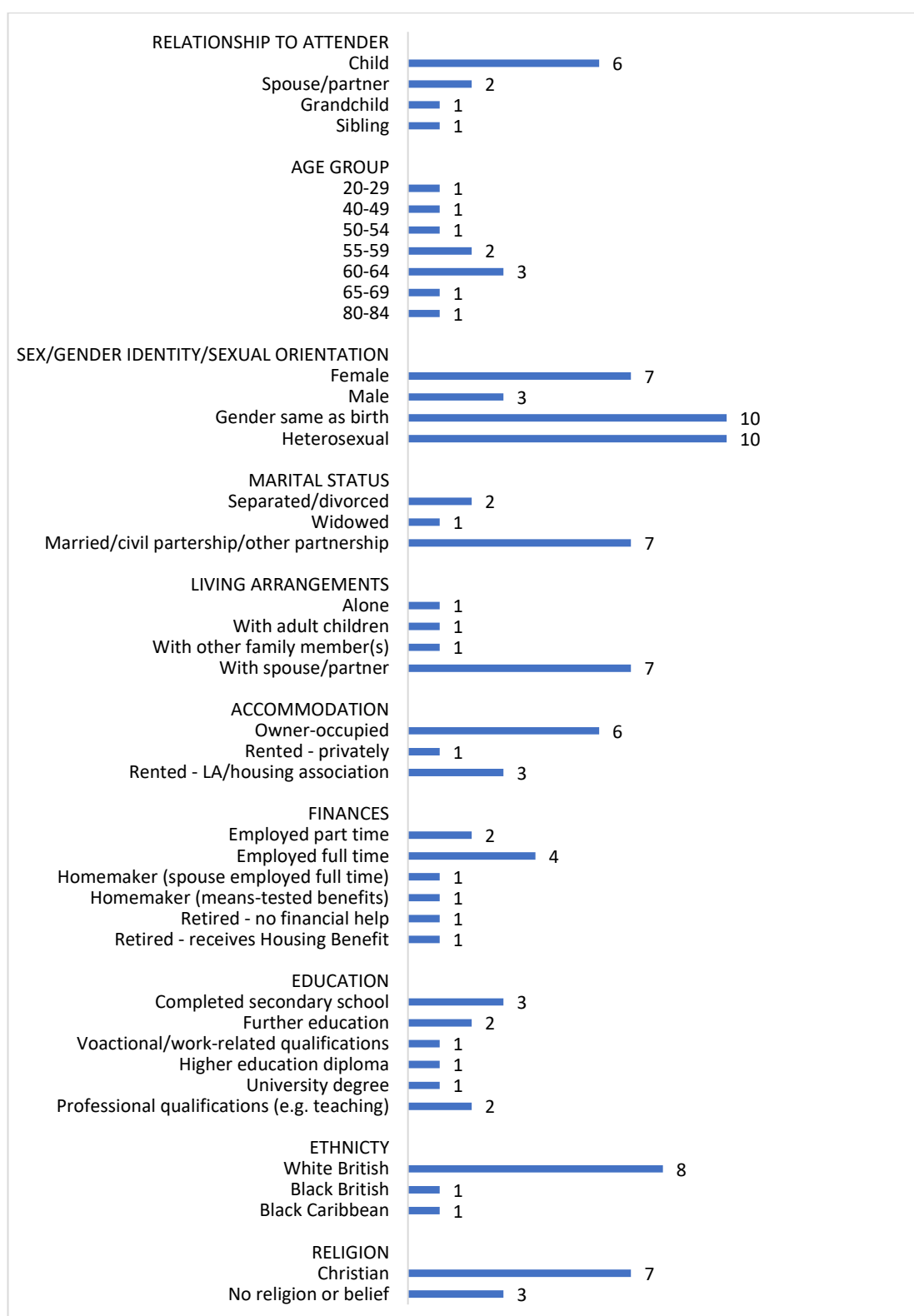
9.2 Carer characteristics

Family carer participants numbered 10: DCHA n=2, DCLA n=2, DCV1 n=2 and DCV2 n=4. Their relatives attended day centres for one (n=4), two (n=4), three (n=1) and five (n=1) days every week.

Carers' socio-demographic characteristics are summarised graphically in Figure 33. By way of summary, most family carers were adult children of attenders (n=6). Two were spouses, one a grandchild and one a sibling. Ages ranged from 28 – 82, with half aged 55-64 years. All carers reported being heterosexual and the same gender as they were at birth. Seven were female and three were male. Most were married or had a partner (n=7), with two separated or divorced and one widowed. Most carers lived with their spouse or partner while others lived with their adult children (n=1), with other family (n=1) or alone (n=1). Four co-resided with attenders. Six were owner-occupiers, three rented local authority or housing association accommodation and one rented privately. Just over half of the carer participants worked, either full time (n=4) or part time (n=2). Two were retired, with one receiving a means-tested benefit and the other receiving no such financial help. The remaining two were homemakers, one supported by their spouse who worked full time and the other by several means-tested benefits. Education levels ranged from having completed secondary school to having a university degree or professional qualifications. The majority (n=8) were White British, with one being Black British and one Black Caribbean; carers were only slightly less ethnically diverse than attender participants. Most reported being Christian (n=7) while three said they followed no religion or belief.

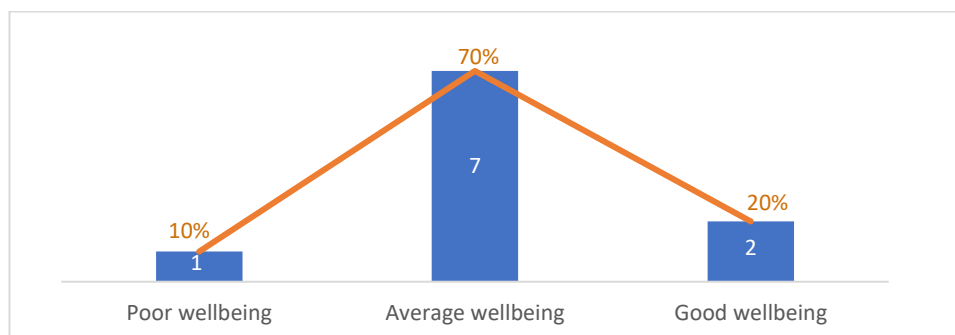
Regarding their health characteristics, six carers reported no health conditions or disabilities. Of the four with health conditions or disabilities, two had one long-standing health condition or mobility difficulties, one had two long-standing health conditions, and one had three long-standing health conditions and mobility difficulties.

Figure 33: Socio-demographic characteristics of family carers



As for attenders' Short Warwick-Edinburgh Mental Wellbeing Scale data (see 7.5.3), carers' scores are categorised into three levels of wellbeing. Figure 34 shows that seven carers (70%) had average wellbeing, while wellbeing was good for 2 (20%) and poor for 1 (10%). Metric scores ranged were in the upper two-thirds of possible scores (7-35) from 20.73-28.13 (23-31 raw score), with an average of 23.98 (26.7 raw) and a standard deviation of 2.61 (2.79 raw).

Figure 34: Carers' levels of wellbeing as measured by SWEMWBS



9.3 Summary of outcomes and what participants valued most

Table 16 summarises the quantitative and qualitative findings about outcomes experienced and participants' most valued outcomes. The nine themes arising concerned feeling reassured, feeling supported and encouraged in their caring role, respite, improved relationship, self-care, feeling safe, social participation, centres as a 'lifeline' and information. Certain aspects of carers' outcomes contributed to a further theme of process outcomes which are discussed in Section 9.5.6.

All except one carer reported gaining from their relatives' day centre attendance. The carer who did not gain viewed attendance as being purely for their relative's own benefit.

Three of the ASCOT domains overlapped with the qualitative themes. Four additional themes beyond those within ASCOT were identified: 1) feeling reassured, 2) two sub-themes of respite which are detailed later in this chapter (practical and emotional respite), 3) information and 4) a 'lifeline'.

There is clear overlap between the 'free time/freedom' element of respite, carers' second most highly valued outcome, and three ASCOT domains of gain. The domain of control over daily life encompasses having the qualitative respite sub-theme of free time to spend as they pleased without having to think or worry about their relative. The domain of occupation covers being sufficiently occupied in meaningful activities, which may necessitate having free time without the

attender. These were two of the three highest scoring domains of gain. Similarly, the joint third highest scoring domain of gain, having space and time to be yourself, requires freedom and having free time to spend as carers please. Thus, the free time and freedom element of respite, was both highly valued and of influence in three domains of gain, where outcomes were measured quantitatively.

Of the four ASCOT themes not reflected by qualitative themes, the broad ASCOT theme of feeling supported and encouraged - in which carers' SCRQoL gain was highest - was similar to, but did not encompass, the slightly differently-focused qualitative theme of feeling reassured which was carers' most highly valued outcome. The other three were self-care, the joint third highest scoring, feeling safe and social participation. The third most valued outcome was the qualitative theme of improved relationships with relatives.

Table 16: Summary of findings about the outcomes of a relative's day centre attendance and those carers most valued

Carer outcome themes	QUALITATIVE FINDINGS (n=10)			QUANTITATIVE FINDINGS (n=10)	
	Carers reporting this outcome	Most valued outcome reported *	Total no. of references within this theme	Carers saying a relative's attendance made a difference to them in this ASCOT domain	ASCOT SCRQoL gain
Feeling reassured	10	6	39	NOT APPLICABLE	NOT APPLICABLE
Feeling supported and encouraged in caring role	NOT APPLICABLE		-	8	Highest gain
Respite:	7	4 (time away from relative, free time and not having to think about relative)	35		
- emotional	6		10		
- free time/ freedom	4		17	9 (control over daily life) 8 (space and time to be themselves) 7 (how carers spent their time, i.e. occupation)	Joint second highest gain: Control Joint third highest gain: Space and time Joint second highest gain: Occupation
- practical	4		8		
Improved relationship with relative	3	2	11	NOT APPLICABLE	NOT APPLICABLE
Self-care	NOT APPLICABLE			7 (how well carers looked after themselves)	Joint third highest gain
Feeling safe	NOT APPLICABLE			6 (how safe they felt)	Fourth highest gain
Social participation	NOT APPLICABLE			4 (contact with people they liked)	Lowest gain
'Lifeline'	1		5	NOT APPLICABLE	NOT APPLICABLE
Information	1		1	NOT APPLICABLE	NOT APPLICABLE
Process outcomes	10 felt reassured			8 (felt supported and encouraged in their caring role)	Highest gain
* Does not total 10 as some carers named more than one.					

9.4 Outcomes as measured quantitatively

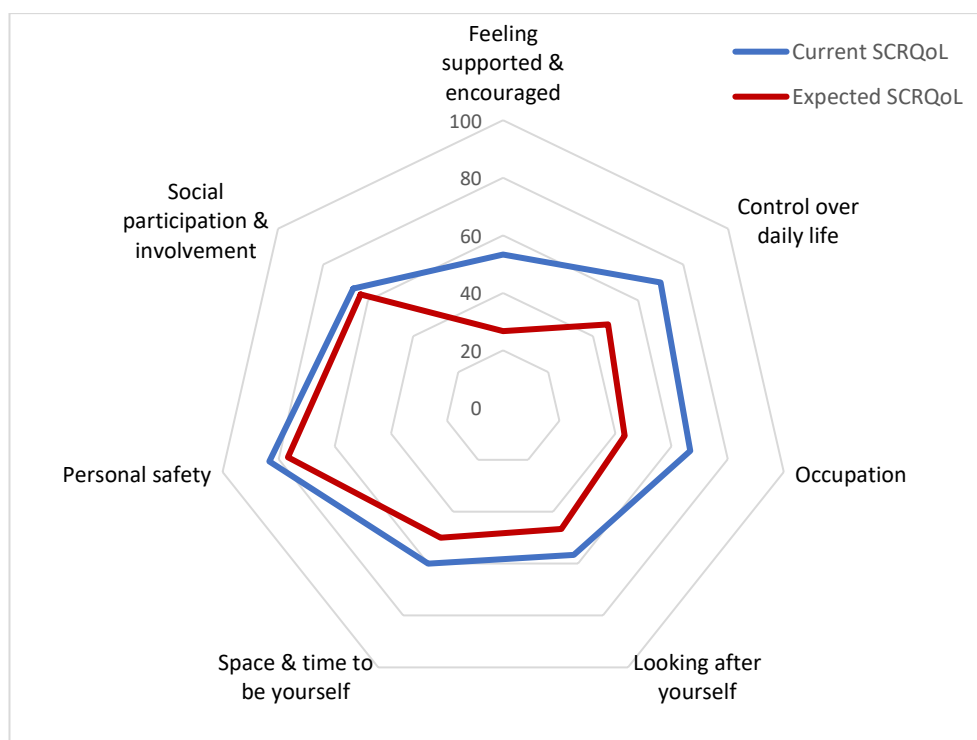
All ten carers completed ASCOT INT4 Carers. Overall average SCRQoL scores were 13.70 (current) and 10.60 (expected), with a resulting overall quality of life gain score of 3.10 that was attributable to day centre attendance. The broad range of individual gain scores (-1.00-8.00) indicates that some carers benefited more than others.

Current and expected SCRQoL are represented graphically, by domain, in Figure 35 and further broken down within domains in

Figure 36 which shows scores as a percentage of the total possible score. These indicate that the greatest gain was in the domain of feeling supported and encouraged. The next two highest domains of gain were occupation and control over daily life, which scored equally. These were followed by looking after yourself and space and time to be yourself, which also scored equally. To a lesser extent, day centre attendance also impacted on personal safety and the least on social participation.

Thus, if centres were no longer attended and the service gap remained unfilled, the highest needs would be in the domains of feeling supported and encouraged followed by occupation, control over daily life and looking after yourself (see Figure 36). Even with centre attendance, carers have some high needs in the domains of feeling supported and encouraged and looking after yourself.

Figure 35: Social Care Related Quality of Life (unweighted) – carers





One carer's gain score was -1.00 which is outside the expected score range. This may be explained by his view, expressed in the qualitative interview, that the centre was purely for the benefit of his family member only and, consequently, did not impact on him. If this carer's scores are excluded, the average gain score is 3.56 which is only slightly higher than when all ten carers are included. While it is possible that these results underestimate gain, the results including this low score are likely to reflect reality since there was also one high score (8.00), and people, their circumstances and capacity for gain, are inherently varied. This group, for example, includes carers ranging in age from 28-82 years and covers spouses, siblings, adult children and grandchildren. Due to the very small sample, data were not further analysed by individual characteristics or day centres attended.

9.5 Outcomes as reported qualitatively

This section draws on the qualitative data to elaborate on the five outcome themes arising: feeling reassured, respite, improved relationship with the centre-attending relative, the centre as a 'lifeline' and information. After this, it presents findings that are likely to have contributed to process outcomes.

9.5.1 Feeling reassured

Carers felt reassured that their family member was - and felt - safe and was being looked after in a supportive environment in which they could ask for help and which alerted carers to concerns (e.g. health-related). They also gained peace of mind from knowing that their family member was able to go somewhere with company and stimulation. One carer felt reassured knowing that their family member felt useful at the centre.

9.5.2 Respite

Three sub-themes of respite emerged:

- 1) emotional, that is experiencing relief, feeling less stressed and being able to relax on day centre days, preventing carer breakdown; one carer related this temporary relief to retaining their sanity and preventing carer breakdown;
- 2) free time/freedom to spend as they pleased without thinking about their family member and without additional company. 'Additional company' included social or health care workers, hairdressers and other visiting paid workers, and the relative themselves who, being constantly present, sometimes felt like a 'chaperone';
- 3) practical, i.e. activities such as housework and packing for holidays became possible, and the day centre acted as 'replacement care', taking over responsibilities assumed by carers on non-attendance days.

The following quotes illustrate these aspects of respite and their overlapping nature:

'It does give me a bit of breathing space. I can relax, watch the telly or put a bit of music on. I can go out, do a bit of shopping, hang the washing out without fear or thinking "Where is she? What is she doing?"' (Wilf)

*'It gives me freedom, a bit of space, a bit of free time. I can sit in my living room on my own. It's one thing I really like doing (...) It relaxes me. Otherwise I'm just highly stressed. I'm like, you know when you're highly strung, you're ready to burn (...) Just to be **alone** in my own house is just the best feeling.'* (Linda)

'if I have to go out and I would be back in time and give him the medication and give him his meals and whatever and then I didn't like leaving him on his own in case anything should happen whilst I am away (...) Now, he's out on his own so I can go and come as I want.' (Barbara)

9.5.3 Improved relationship with day centre attender

Carers attributed improved relationships between themselves and their day centre attending relatives to their relative's improved sociability, mood and being more like their 'old self'.

9.5.4 Lifeline

The centre's combination of benefits meant it functioned as a 'lifeline' for one carer and their wider family. This resulted from a combination of relief from constant phone calls due to 'improper' use of an alarm system, regular weekly suicide-threatening phone calls and feeling reassured that the family member was physically safe, felt safe and useful, and was somewhere she knew she was liked.

9.5.5 Information

Although one carer had been given helpful information about a carers support organisation by the centre, on making enquiries, she discovered that it offered daytime support only which meant she was unable to use it as she worked full time. Nine carers said they had not accessed any additional practical information or support via centres.

9.5.6 Process outcomes

Process outcomes pertain to the way services are delivered. For carers, these include having confidence in the service, having a 'say' in it, feeling a sense of shared responsibility (Qureshi *et al.* 1998) and value for money. Carers' experiences influence process outcomes which, in turn, may influence both the overall outcomes they gain and the way they feel about their family members' day centre. The following four sub-sections consider the contribution of experiences to these process outcomes.

General contributors to process outcomes

Four factors suggest that day centres did focus on at least some process outcomes for most family members of attenders. These factors were carers' overall positive feelings, that they planned for their relative to continue attending, would recommend the centre to others and considered centres to be good value for money. While it is possible that these feelings resulted from the relief and break they enjoyed on day centre days, it is also possible that they were due to the outcomes they observed their family members to experience. Each of these is now further detailed.

1) Overall positive feelings were reported despite some initial or continuing reluctance on the part of attenders.

Three carers felt comfortable or happy about their relative going to their day centre and a fourth felt safe knowing '*she will be safe and looked after*' (Nancy). One of these carers felt lucky that this model of support suited her family member well. Two carers looked forward to day centre days. Three did not talk about their feelings concerning their relative's centre attendance.

The perceived reluctance of some relatives to go to their centres, either at the beginning or on a regular basis, was highlighted (n=4). Three relatives had initially not been keen, because the centre was located in a disliked area, because a widowed relative did not wish to go alone and because of lost confidence, but all thought their relative enjoyed it once there. One carer had accompanied the attender on their first day. The fourth carer found her relative's persistent reluctance to attend the centre frustrating since she clearly enjoyed it and talked about the day afterwards. The carer attributed this reluctance to shyness and said '*you **can't** force someone to go if they don't want to, but I don't understand why she doesn't. She enjoys it. Every time she goes she enjoys it. She talks to other people. She has something different to do. She brings back things. (...) I think she sometimes thinks she's doing them a favour going, 'cause she's like adding to the numbers (...) she does enjoy it, I don't care what she says*' (Frances).

2) All ten carers said they planned for their relative to continue attending their centre or hoped they would be able to do so. One, who was planning a house move, said they would look for one in their new area.

3) All ten carers said they would recommend the use of day centres, whether this was very strongly (n=6), quite strongly (n=1) or just recommending (n=3) them:

*'It's a **nice, clean** place and they **really** look after them.'* (Barbara)

'I think they're great, they're super (...) They're all so friendly and lovely and [relative] enjoys that.' (Frances)

Two, however, said that the idea of attending a centre did not attract them personally and, likewise, with attenders, *'It's up to the individual, isn't it? Everybody's different, aren't they?'* (Wilf).

4) Nine carers considered the cost of attendance for their relative to be excellent (n=1) or good (n=8) value for money.

Carers conceived value for money in terms of the benefits to them and what the centre offered to attenders, including transport:

'she gets a lunch and she gets a social engagement. It gets her out of her flat and (...) that's money well spent (...) it is good value for her, because it does all those things about keeping her mentally and socially active.' (Brian)

'Quite frankly, if she couldn't afford it we'd make sure we did (...) She's there a long time. She's got her transport which is very important (...) She gets a good meal (...) And she gets entertainment (...) She is just like her old self more there.' (Evelyn)

However, whether attendance was considered good value for money also depended *'on their tastes and stuff like that'* (Nancy) and also on individual financial resources, with some implying the cost might be off-putting: *'there are a lot of people who I am sure [charge] a day puts it out of reach for them'* (Brian). Increases in charges were mentioned (n=3), although not considered problematic.

Having confidence in the day centre

High levels of confidence in centres were implied by the peace of mind carers said they experienced knowing their relatives were somewhere with company and stimulation, from the reassurance carers felt about relatives' safety while at centres, carers' positive comments about managers, staff and volunteers and because they said they knew their family member was being looked after.

Carers were complimentary about staff, volunteers and managers (n=4) although not all had had much contact with them. Several had visited centres and found them to be courteous and pleasant. One carer said her relative talked about the manager's supportiveness. Talking about volunteers, one carer said:

*'They've **always** been so courteous, kind and helpful to me (...) I found them all to be incredibly helpful, very professional (...) They look after them **really** well (...) they were certainly very friendly, chatty and, what would be the word, enthusiastic almost'* (Frances).

However, carers did not always know what was happening at centres. One had not been given any information about what went on at the centre but was happy with this. Another, who had not been told about an incident by her family member, had rung the centre to get further information, finding the staff member who responded to be very helpful and informative, but this was that carer's only contact.

Occasional lateness of transport was irritating for carers and sometimes meant relatives missed the start of the day at their centre. Indeed, transport provision was considered important, as was its reliability (n=5).

Having a 'say' in the day centre service

Positive feelings towards centre staff and volunteers suggested confidence in approaching them, but no carer commented on opportunities or mechanisms to give feedback to day centres although a small number had mentioned contacting centres about specific incidents. Choice, whether of service type, day centre or attendance days, also went unmentioned by most carers. Three carers mentioned choice while accessing the service. For one, a hospital social worker had not offered choices, instead only suggesting that one centre. Other services, such as a dementia café, were proposed by professionals visiting to speak to a family member about dementia who rejected these. The third carer had chosen the closest of the centres suggested by their social worker.

Having a sense of shared responsibility

Day centres' input on health matters was said to be useful (n=2). One carer appreciated the centre calling the GP or ambulance directly when necessary and the other said it was helpful that the *'manager is easily accessible and easily approachable and she's let me know when she has had concerns, which has been helpful. Sometimes when you are with somebody a lot and you think something is not quite right, but maybe I am just thinking it. Then when you get confirmation from other people, you think, okay, so maybe a trip to the doctor is in order'* (Kate). This active monitoring of family members' health and the positive comments about managers, staff and volunteers suggest that carers felt responsibility for care in certain areas was being shared. However, their suggestions for improvement (discussed in the next section) implied that there was room for improvement to communication, and the provision of counselling for attenders somehow might have provided additional emotional support for one carer. The high SCRQoL gain score in the domain of feeling supported and encouraged is also relevant to this outcome.

It is possible that responses may have differed had family members attended more often or if more carers were co-residing with attenders.

9.6 Suggestions for improving the service

Eight carers made suggestions for improvement (see Table 17). Although asked about potential improvements for carers, several suggestions focused on attenders.

Carers made what they knew to be unrealistic suggestions as well as more realistic ones concerning extensions to what was currently offered and improvements to current practice. Only three suggestions implied criticism.

Suggestions acknowledged to be unrealistic were for more operational hours or days. While one carer wanted only one additional day for respite, the other wanted five-day operation. She benefited from the reassurance and knew her relative benefited *‘from that **environment** and that **purpose** and the **socialisation**’* (Lisa). For this carer, six-day operation would have been ideal, even if at weekends it was *‘a lunch club, because a lot of people live on their own and have no families (...) they struggle cooking for themselves. I suppose the only thing again is sort of transportation as well’* (Lisa).

Table 17: Carers' suggestions for improvement

Positive suggestions	<ul style="list-style-type: none">• Operational day longer (n=2).• More than one operational day a week (n=2).• More trips out (n=2).• Availability of a trained counsellor (n=1).• Improved communication with carers (n=3).
Negative suggestions	<ul style="list-style-type: none">• Transport to arrive at specified time (n=1).• Identify checks to be carried out after opening the day centre security door (n=1).• More varied food (n=1).

Communication-related improvements suggested concerned general communication with carers, feedback about relatives and the use of technology. Invoices need not be carers' only contact with the day centre; *‘the more support and help they can give the **carers**, the more they can actually help the individual concerned (...) They need to look **beyond** the people who go to the day centre. They need to look to the people who get them there in whatever capacity’* (Brian). Regular feedback on attenders regarding health, behaviour or any incidents that occurred, in the same way as schools inform parents about pupils, would be welcomed. As well as helping carers to make helpful adjustments for their relatives, this would ensure that facts were transmitted without potentially erroneous interpretation by attenders and would enable carers to know when to seek help, for example from doctors. Information about the centre programme would enable carers to encourage attenders to opt into, for example, trips, and to ensure they had adequate money and were dressed appropriately on the day. Information about other support or opportunities for older people in the area could also be provided. One carer had seen publicity about exercise classes and falls prevention in the area displayed at another centre. Although this would not be the best

option, since carers did not always visit centres, information about other opportunities and the centre programme could be provided in a newsletter, perhaps being sent with the invoice. Invoices and newsletters could be emailed, making better use of technology. This happened at one centre and the carer reported appreciating the *'newsletter which they send to me by email now so that (...) I'd know about everything now'* (Frances). It was only recently that payment by bank transfer had been made possible at another centre. Another carer pointed out how easy it was to use technology:

*'These days with technology, none of this stuff is hard, is it? A website you can check. Register your mother for those things that you want her to do, whatever. There are **more** ways of doing it. I don't know whether they've got any sort of social media underway'* (Brian).

9.7 Outcomes for carers as perceived by attenders

Attendees' perceptions of outcomes gained by their family carers echoed carers' two most valued outcomes, respite and feeling reassured. Half of the attendee participants (n=11) cited elements of respite they thought their carer derived, namely free time to use as they please, a break generally, the ability to get on with things that need to be done and reduced worry. Nine thought their carer felt reassured that they were safe, cared for, with company and stimulation, and gained pleasure from knowing they had somewhere to go and something to do and from seeing them happier. Three attendees thought their day centre attendance had no impact on their family members. Two did not offer any views.

9.8 Summary

Family carers of day centre attendees were diverse. Similar outcomes of a relative's day centre attendees emerged from quantitative measures and qualitative interview data. The greatest quality of life gain, measured quantitatively, related to feeling supported and encouraged. The most valued outcomes were declared to be feeling reassured or having peace of mind that their family member was safe, being looked after, was out and had social and mental stimulation, had a purpose, had someone to share concerns with and that any health or wellbeing concerns would be communicated, and respite. Sub-themes of respite were emotional relief, being able to accomplish practical tasks and having free time or freedom to spend as they pleased without additional company and without thinking about the family member, with such free time being the second most valued outcome. Some carers' relationships with their family member had also improved. One had gained information. It was a lifeline for one. Overall, there was a quality of life gain for carers that was attributable to a relative's day centre attendance. The low ASCOT gain score may reflect the low number of days spent at centres, and that only four carers and attendees co-resided. One carer reported no benefits. Carers were generally happy with what day centres

provided. Although process outcomes were addressed to a certain extent, their ideas for change suggest room for improvement in certain areas.

Attendees perceived that their family members benefited from knowing they were safe, being cared for and had somewhere to go that offered social and emotional stimulation, from seeing their family member was happier, and benefited from the respite centres provided.

PART 2: DAY CENTRE VOLUNTEERS AND FRONTLINE STAFF

After outlining the approaches used for gathering data, this part summarises the characteristics of the overall staff and volunteer sample participating in this study and their roles. Next, the unique contribution that volunteering or working in a day centre made to participants' lives, as recounted in qualitative interviews, are detailed. Volunteers' and staff's feelings about their day centres are then set out. Finally, the findings of this section are summarised. Managers' views of outcomes this group experienced were set out in Chapter 6.

9.9 Approach taken to gathering data

Face-to-face qualitative interviews gathered data about participants and their outcomes, views and feelings. On average, these lasted 40 minutes (range 15-79 minutes).

To discover whether day centres made a unique contribution to participants' lives, they were asked whether volunteering or working there added anything to their lives that they would not experience otherwise. How participants felt about volunteering or working at day centres and what they liked best about this were also explored. Volunteers were asked for any suggestions they had to improve their experience. Finally, participants were asked whether they planned to continue in their roles and if they would recommend volunteering or working in day centres to others.

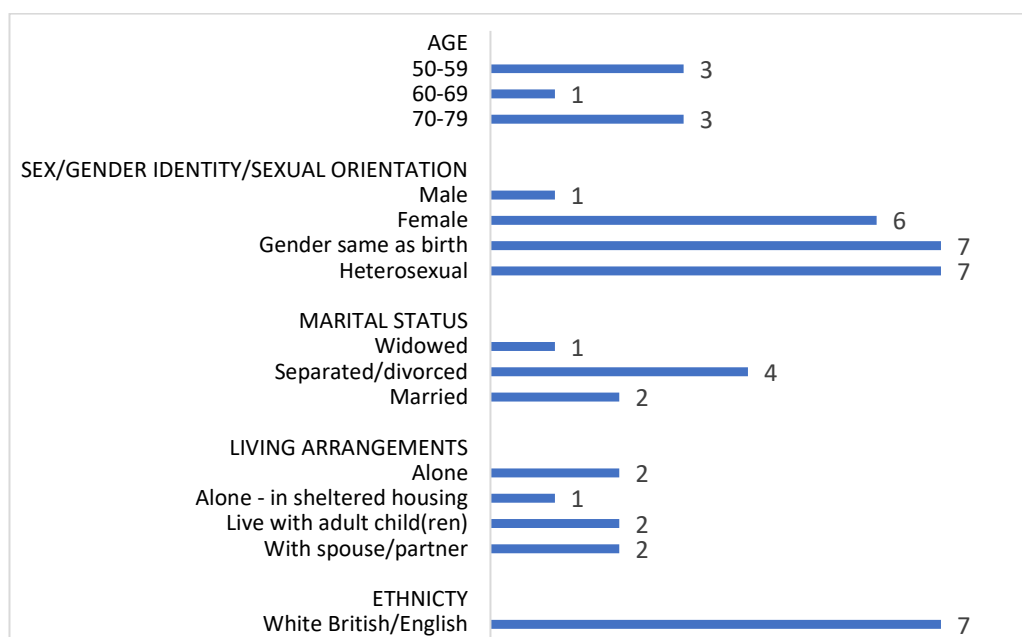
9.10 Volunteer and staff characteristics

The sample of 17 included frontline volunteers (n=7) and frontline staff (n=10) working in day centres. Their characteristics are summarised below.

9.10.1 Volunteers

Figure 37 provides an overview of participants' socio-demographic characteristics. Volunteers ranged in age from 57-77 years. Only one was male. All reported being the same gender as at birth and heterosexual. Their marital statuses included being separated or divorced (n=4), widowed (n=1) and married (n=2). They lived alone (n=3), with adult children (n=2) or with a spouse (n=2). All were white British or English; six volunteered at the two centres with no ethnic diversity. All but one volunteer had health conditions or disabilities. Four volunteers had one type of health condition or disability, one had two types and one had four types of health condition or disability. These included long-standing health conditions (n=5), mental health conditions (n=3), hearing (n=1) and sight impairment (n=1).

Figure 37: Socio-demographic characteristics of day centre volunteers



Volunteers had been in their roles for an average of 3.7 years (range 3 months to 7 years, median 5 years). They volunteered at centres for one day (n=5), two days (n=1) or three days (n=1) for an average day of 4.6 hours (range 3-5.75 hours, median 4.5 hours). They volunteered for an average of 6.7 hours weekly.

Four talked about what they did in their roles, much of which involved taking initiative. They supported attenders to enjoy themselves, thought of stimulating activities, supported attenders during activities, reassured anxious attenders, made and served refreshments, served lunch, helped people walk to the toilet, moved furniture, chatted with attenders and collected money. 'Troubleshooting' was also mentioned, such as sewing on buttons, running errands for attenders to local shops (e.g. buying cards) and one had assisted an attender to buy a bed. One saw herself as an extra pair of hands to reduce staff's workload. Another had moved from her frontline role to lunchtime kitchen work, but joined the main group for part of the day.

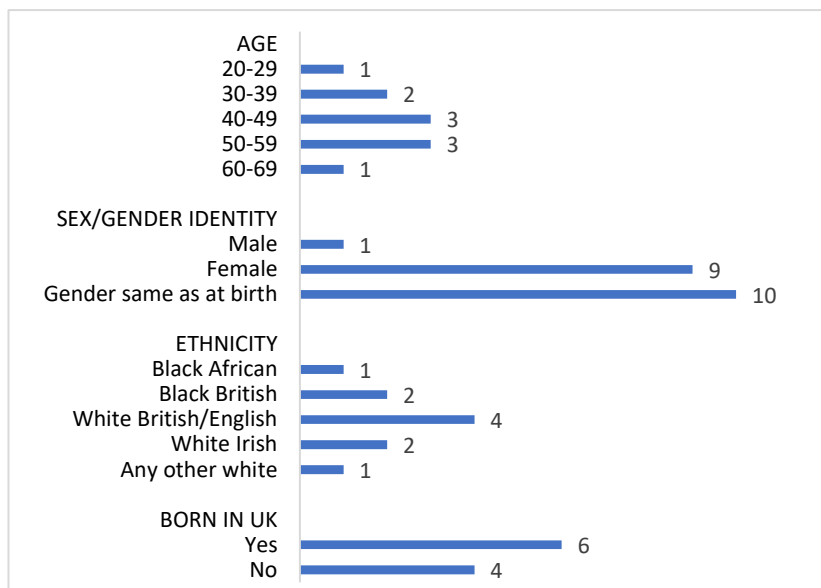
Six participants started in their roles after retiring (or in the process of retirement), having wanted to have structure or something to do (n=4) or had fallen into volunteering accidentally (n=2). Three had specifically wanted to work with older people. One's changed personal circumstances had prompted volunteering which she had done to regain confidence and to make community links.

9.10.2 Staff

Figure 37 gives an overview of participants' socio-demographic characteristics. Staff ranged in age from 22-60 years. All but one were female, and all reported being the same gender as at birth. Six were born in the UK; the four born elsewhere had resided in the UK for one, 10, 12 and 30 years

respectively. The range of ethnicities included White British/English (n=4), White Irish (n=2), Black British (n=2), Black African (n=1) and Any Other White (n=1).

Figure 38: Socio-demographic characteristics of day centre staff



Staff had been in their jobs for an average of 8.7 years (range 3 months to 18 years, median 7.75 years). The one working for the shortest period was also the youngest.

Most participants were described as care/support workers (n=8). One was an activity specialist. One was a senior care worker, who managed other care workers, and also held a specialist stroke role. This involved key working with the stroke clients, planning and running the twice weekly stroke group (rehabilitative activities) and carrying out referrals (e.g. to GPs, physiotherapists, occupational therapists, social workers). Although more personal care was undertaken in the two centres accepting local authority referrals only, all roles were varied, described by one as a 50/50 care and social role. They involved:

- personal care: support with eating, filing/painting fingernails, toileting (*assisting to the toilet and checking if help is needed, in the toilet – with clothes and/or wiping, changing pads, cleaning up and/or showering after continence ‘accidents’*)
- planning, running and supporting activities, playing games with attenders, organising occasional events
- emotional support (*e.g. chatting, ensuring attenders feel welcome, are happy, comfortable, entertained, having fun, encouraging them to relax, being attentive to their wants and needs, trying to ensure attenders feel included if they cannot or choose not to join in*)
- monitoring attenders’ wellbeing and health, often by chatting on arrival or during the day, and acting where necessary (*e.g. discussing action, contacting family*)
- making and/or serving refreshments and serving lunch

- practical support (*e.g. arranging appointments, helping people to move around, escorting to bus, troubleshooting such as arranging for an attender's broken boiler to be mended*)
- attending to logistical requirements (*e.g. ensuring equipment is available for activities, arranging seating and tables, setting out reading material, setting up the kitchen for lunch, getting cups ready, washing up, setting table for lunch, putting music on, collecting money, tidying up, taking lunch orders, taking coats, ensuring attenders took their bags home, telephone to arrange transport*)
- acting as a key worker for named attenders and maintaining paperwork (*maintain files, carrying out reviews, risk assessments, record problems, contact family where necessary*)

Activities immediately prior to this role included being a full-time parent, a personal assistant, a hairdresser, cleaner, working at another day centre (older people, mental health or physical disabilities), a care home/extra care facility, as a social services officer or working at the same centre before its clientele changed from being people with learning or physical disabilities to older people. It was one participant's first job. Four had worked with older people before their current jobs. Data concerning pay scales was outside the remit of this study.

All participants had undertaken a range of practical training courses relevant to their work (see Table 18). Specialist courses, perhaps more relevant to attenders with higher needs, had been undertaken by a handful of staff at the two centres that accepted local authority referrals only. Training had also been undertaken with respect to activities provided. Qualifications held, or being prepared for, included National Vocational Qualifications (NVQs). One participant was the internal dementia specialist, a role entailing delivering short training sessions to other staff, but time constraints posed difficulties for this. Some training was in-house, some had been delivered by external trainers and some was online, often undertaken in staff's own time using their home computer. Training was a mix of face-to-face and electronic. This data may be incomplete as not all participants referred to their training records.

In addition, two staff cited relevant training they had gained from their university degrees. One was trained in physiotherapy, having a degree in Sports Science which encompassed osteology (bones), myology (muscles) and kinesiology (movement). The second had undertaken drama and music training as part of her degree. Another staff member, who led a discussion group, held a Master's degree in the arts.

Table 18: Training undertaken by staff

Type of training	Details
Practical training courses relevant to their work (undertaken by most participants)	Moving and handling of people, first aid, food hygiene, fire safety and health and safety. Personal care training was said to be included in moving and handling courses. Some courses covered use of hoists.
Other practical training	Medication administration/storage (n=6), safeguarding awareness (n=3), manual handling in emergency situations (n=1), mental health first aid (n=1) and dementia and mental health awareness (n=4), learning disability awareness (n=1).
Specialist training	Infection prevention and control, nutrition and hydration, diabetic awareness, epilepsy and pressure sore/ulcer awareness. Diversity and inclusion training (n=2, one per centre). Trusted Assessor certification enabling assessment for community equipment to assist with activities of daily living (n=1). Working relationships and handling of information (n=1).
Activities	Chair-based exercises (n=2), healthy eating (n=1), craft (n=1) and stroke, the impact of brain injury (n=1).
NVQ qualifications	Level 3 NVQ in Health and Social Care (n=3). Level 2 NVQ part-completed (n=1). NVQ level 2 in Health and Social Care equivalent (from another country). NVQ assessor (n=1).

9.11 The unique contribution of day centres to their volunteers' and frontline staff's lives

All but one in each group said that volunteering or working at day centres made a unique contribution to their lives (volunteers=6, staff=9). Some said it had added multiple things to their lives. The person who said that volunteering did not add anything unique to their life said that it was one of many options of how they could spend their time and they simply volunteered because they wanted to. The staff member who declared that working at the centre did not add anything to her life said that, despite this, it had made her more aware of people and this addition attenuated the initial comment. Participants' responses were categorised into the themes: 1) mental wellbeing and health, 2) people, and 3) skills or knowledge acquisition or transfer.

9.11.1 Mental wellbeing and health

Most of what volunteering at a day centre was reported to have added was related to mental wellbeing or health (n=5). It gave volunteers something to look forward to (n=2), improved their confidence (n=2) and provided fulfilment (n=2). Improved confidence helped one volunteer manage her own problems and another overcome her shyness, difficult emotions and feel like a *'helpful, valid member of society'* (Volunteer5). One person, who lacked other immediate ties or responsibilities, felt fulfilled by the sharing and interaction that took place at the centre. The other gained fulfilment from giving:

'as a volunteer if you love what you do you get as much back as you give to them if you can make them smile and feel special (...) makes me a much happier, kinder person' (Volunteer2).

One volunteer's diagnosed mental health condition had not relapsed since volunteering which she attributed to improved wellbeing gained from this volunteering work, while another said that *'it just enhances life generally (...) It's just good fun'* (Volunteer7). Talking about how volunteering had helped her depression, a third said:

*'Oh terribly, oh gosh, I can't, can't tell you how much (...) we divorced (...) And from something sad in your own family life, this has helped me gradually bounce back and feel me again which is certainly very worthwhile, **very** worthwhile (..) I feel a bit more like me (...) which is a good thing. And it's through volunteering, you know'* (Volunteer5).

As for volunteers, working at a day centre added aspects of mental wellbeing and health to participants' lives (n=8). They derived feelings of satisfaction (n=5) or worth (n=1) from seeing that their support made a difference and from knowing their service provided something attenders may not get elsewhere. Their work made them happier (n=2), more confident (n=1) or feel *'better as a person'* (Staff10) (n=1).

One staff member said it have given them back their identity after moving from providing care in a task-focused and time-constrained residential setting which felt *'soul-destroying'* (Staff5). Another had two diagnosed mental health conditions; the symptoms of one had lessened and the other was in remission.

9.11.2 'People'

Among those mentioning the social aspect of their role as volunteers at day centres, some considered it 'added people' to their lives (n=3). They either enjoyed meeting the people there or had made friends with other volunteers which, for one, counteracted potential isolation:

*'I'm not just isolated and I am seeing **all** sorts of ages and not just people of **my** age.'* (Volunteer4).

Similarly, working at the centre gave staff contact with older people and the chance to be involved in the lives of and build relationships with the people they supported (n=3).

9.11.3 Skills/knowledge acquisition or transfer

Volunteering provided the opportunity for skills transfer (n=2) either from former work to the volunteering role or to use skills learnt from volunteering elsewhere (e.g. first aid, moving and handling).

Staff members said they had learnt from the older people they supported (n=2). They had learnt about the value of family and how family members can support each other, that everybody is different, had benefited from seeing people's resilience and desire to enjoy life and acquired cultural knowledge about the UK.

9.12 How volunteers and staff felt about their day centres

This section reports how participants felt about volunteering or working at day centres, what they liked best about this, any suggestions for change made by volunteers and whether they planned to continue in their roles and if they would recommend this to others.

9.12.1 Feelings about volunteering or working at day centres

All seven volunteers talked about their feelings about their roles at day centres. Some talked about how much they enjoyed volunteering at them (n=4). Three volunteers acknowledged that they donated their time and efforts because they want to help and that they also benefited from doing so; volunteering was a 'lifeline' for one's wellbeing. Other volunteers enjoyed the structure volunteering added to the week (n=1), the one-to-one work (n=1), the flexibility that enabled one to take days off as needed (n=1) and the training undertaken in the role (n=1). As the following quotes suggest, they could also see the difference that centres made to attenders, with one volunteer going as far as saying that she would be likely to attend it herself later in life:

'I love it when we've got music or anything like that, her [the attender's] whole face lights up. That gives me a lot of pleasure when you see somebody, you know, she comes in sometimes and she doesn't know if she really wants to be there. Then she listens to some music or the exercises (...) Her face, it lights up. You think, oh, that's worth coming for, really.' (Volunteer6)

*'I'd miss it if I didn't have this. It's the best voluntary work I've done and I've tried different voluntary sectors. Out of all of them, even work, paid work, this has been the best. I will carry on until (...) I'm told we don't need you as a volunteer. I definitely, I would use it as a place to come to not be at home isolated. If my legs are wobbly and the transport could pick me up. What more could you ask for in a day centre? (...) In relation to all jobs I've had in my life, I've never known **anything** like it.'* (Volunteer4)

Three volunteers felt very appreciated and looked after. One felt overloaded and insufficiently appreciated, believing this to result from having proved herself competent at taking initiative, although she acknowledged the manager's special efforts to look after her physically, given her health condition. Those who felt appreciated commented upon enjoying specific events for volunteers, supportive staff and the manager's attitude. One volunteer commented that the manager was *'forever saying, thanks to everybody (...) Because obviously, without all the volunteers, (...) if they all stopped it wouldn't run. She's very **thoughtful** indeed and **amazing** her memory for what people are doing and what have you'* (Volunteer7).

Other volunteers and staff were felt to be efficient and caring (4) and, for a few, to feel like family (n=2). One referred to volunteers, staff (office and frontline) and the manager as a *'wonderful crowd'* (Volunteer2). Having male volunteers was felt to be helpful for male attenders. One volunteer's liveliness was apparently popular among attenders. Another noted how caring the manager was and smiled while describing how the *'[manager] goes to town with parties (...) she has a proper cotton tablecloth. She really gives the elderly respect, love and kindness (...) I was*

overwhelmed when I saw the first party. The way they dressed the tables and each one has a name on a little ball thing. It's wonderful. She makes them feel special' (Volunteer4).

Nine of the ten staff interviewed talked about their feelings about working at a day centre. They were overwhelmingly positive, with seven saying they looked forward to, loved, enjoyed, were happy in or proud of their work:

*'I've never come into work fed up, saying I don't want to do it. You know what I mean? It's looking **forward** to coming to work and **enjoying** it.'* (Staff3)

*'I am **proud** of what I do. I feel I am proud that I am able to come here and just be myself as well.'* (Staff8)

Work was satisfying (n=5) and fun (n=3) although sad when attenders died (n=2) and exhausting (n=3), mainly emotionally:

*'Yes, because you think, how can I be tired, you know? I've been like sitting down, doing an awful lot of sitting down, drinking tea and stuff like that. But that is actually **really, really** important part of the job. I think how can you be so exhausted? But it is exhausting. (...) **Emotionally** exhausting I think more than anything. I think, yeah.'* (Staff6)

Working with people had the added benefit of meaning that *'every day is what you make it. You get out what you put in and it's always slightly different'* (Staff5). However, staff said that one had to be a 'people person' (n=2) and patient (n=1) to do the job, while an added bonus of the role was that staff could 'be themselves' (n=2) which added to their pleasure.

One felt that there was insufficient time in which to do everything they would like to have done. Regular supervision was said to be important for senior staff's awareness of work and anything that needed to be addressed (n=1) as were staff meetings for discussing ideas, problems and activities (n=1). Being thanked for one's work by a manager was highly valued (n=1).

9.12.2 The best things about volunteering or working at a day centre

The most commonly reported best things about volunteering at a day centre were the satisfaction gained from doing something useful and feeling needed (n=4), interaction with the people (n=4) and feeling part of a team (n=3). Volunteers talked about feeling 'warmth' from attenders and enjoying their different characters and laughing with them. The whole environment was said to feel rather like an extended family. One particularly enjoyed joining in with the organised group activities. Another enjoyed the peaceful journey through the countryside which de-stressed her and contrasted sharply with her previous volunteering position to which she arrived feeling stressed because of the traffic. A third enjoyed being able to apply the skills she had learnt during her paid working life.

The most commonly named best things about working at a day centre were the pleasure gained from working with people (n=8) and being able to see the impact of their work (n=7). Staff talked

about enjoying interacting with people generally, enjoying interesting conversations with attenders and that attenders were willing to join in activities and engage in conversation. They were pleased to have good colleagues who worked well together as teams: *'there is oodles of teamwork here. It's just great'* (Staff4). Making a difference included seeing attenders' moods improve or knowing that weights were lifted from their minds, seeing them being proud of their achievements in craft or *'just being **there** for them and making sure they are okay'* (Staff10). A further dimension was that their work felt satisfying (n=4) because they could see the results of their work or because they also gained by feeling worthwhile:

*'the first thing they tell you when you start working here is how much they **value** and how much they look **forward** to it and almost they said like it's like dead days in between'* (Staff5).

Staff also particularly liked that their work was fun (n=2), supporting attenders' independence by encouraging them to do things for themselves if they were able (n=1) and one appreciated the shorter hours than in her former work in residential care (n=1).

9.12.3 Volunteers' suggestions for change

All seven volunteers said they were happy and would not make any changes to make their role better for them. One then commented upon the inherent background noise and interruptions intrinsic to a shared building, the impact of which might be lessened by different seating arrangements.

A few commented upon 'little niggles' (n=4). These concerned others' non-use of a 'uniform' introduced for security purposes, receiving inconsistent instructions, not being told certain things they needed to know in advance, certain volunteers occasionally being over-precious about their role or difficult, and one particular attender who was felt to be favoured despite being rude to volunteers and inconsiderate to co-attenders and visiting speakers. One said they would not like to have to provide personal care which, currently, was optional.

Some volunteers pointed out that their feedback and suggestions were always welcomed or could be given through official mechanisms, such as committee meetings (n=4).

9.12.4 Continuing to volunteer or work at a day centre and recommending this to others

All seven volunteers planned to continue at their day centres, with one of the two youngest volunteers (age 57) also planning to look for further volunteering opportunities elsewhere, parental caring responsibilities permitting. While two said they would continue until they 'dropped', two said their worsening health would affect how long they continued. All seven also said they would recommend volunteering at a day centre to others. Most answered

enthusiastically. However, one volunteer, while recognising that daily demands on staff varied and that staff absence and attendance levels affected workload, pointed out that a centre employing staff should be adequately staffed and should not require volunteers.

Nine of the ten staff said they planned to continue working at their day centre, but one said this would depend on being able to overcome a recently-occurring family-related logistical difficulty. One felt she had worked in the role for long enough. She planned to continue with social care work, but wanted to study and then apply for management roles while, somewhat contrarily, emphasising her dislike for paperwork and preference for working with people. All ten staff said they would recommend working at a day centre to others.

9.13 Summary

Volunteers were older people themselves, mostly single and with health conditions or disabilities. All were White British or English. Staff were more diverse in age and ethnicity. Only two of the volunteer and frontline staff participants were male.

The majority said that volunteering or working in a day centre made a unique contribution to their lives. For most, this related to mental wellbeing and health. Some volunteers also gained from the social aspects involved and some staff from the chance to build relationships with those they supported. It also gave an opportunity to use existing skills or knowledge and to learn from older people. Some derived enjoyment from meeting and interacting with people or simply the whole experience of volunteering or working at a centre.

Feelings about volunteering or working in a day centre were mainly positive, with all saying they would recommend volunteering or working at a day centre to others and all but one planning to continue at their day centre. Volunteering was enjoyable for many, it had helped them and they could see the difference centres made to those they supported there. They particularly enjoyed feeling useful, interacting with people and feeling part of a team within an environment that felt rather like an extended family. One, however, felt under-appreciated. One staff member wanted to move up the career ladder. Work was said, by most, to be enjoyable, satisfying and fun but exhausting and, occasionally, sad. A small number highlighted the lack of time to do everything they would like to have done and the importance of supervision. The job's best aspects were the pleasure gained from working with people and being able to see the impact of their work.

Chapter 10 Discussion

The main aim of this study is to improve the understanding of the purpose and role of generalist day centres, how they are viewed and their use within a changing policy and practice context. The findings show a varied and changing sector presenting several themes for consideration.

This chapter opens with a brief recap of the context of this study, its objectives and methodology and a summary of its main findings. These are then discussed in the context of their contribution to other evidence, current debates and the conceptual framework for this thesis which rests on day centres' potential relevance to the policy commitment of ageing in place and perceptions of centres as potentially stigmatised institutions.

10.1 Summary of study background, objectives and methods

Policy and practice changes and the current environment of reductions of public funding to social care mean that the context in which day centres for older people exist has changed considerably. Day centres have been under-researched as whole services, and much of the research about them was undertaken in a different policy and funding context, or concerned centres specialising in dementia care.

This study set out to paint, from multiple perspectives, a rich and contemporary picture that could be used to determine if and how such services may be optimised to improve the health and wellbeing of older people and maximise the impact of the health and social care system.

The first research question was addressed by a review of the literature published from 2005-2017 which established the extent of the existing evidence about day centres' purpose, perceptions of them, who benefits from them and how. The findings, in Chapter 4, confirmed the gaps in knowledge that this study aimed to address. Using mixed methods within a multiple, embedded case study design, research questions 2-5 were addressed by investigating what four day centres offered, who used them and how, their experiences, what centres contributed to the lives of those involved in them, the centres' relationships with primary and community health care services and perceptions of day centres, their place within the market of social care provision and their potential development. For each day centre, the perspectives of four embedded groups of individual participants (n=69) were gathered: older people attending them, their family carers, day centre managers, frontline staff and volunteers, and local authority social care staff.

Fieldwork consisted of 14 weeks of visits to each of four day centres and individual face-to-face semi-structured interviews. Qualitative methods were employed to explore participants' perceptions, reasons for attendance and experiences. Outcomes of attenders', carers', staff's and

volunteers' involvement with day centres were explored qualitatively; validated tools were also used with attenders and carers to measure outcomes. Validated tool and socio-demographic data were used to describe attenders' and carers' characteristics. The use of standardised tools with these participants aimed to discover whether collecting data in this way might form a robust evidence base for day centres which they might find useful in their business planning. Day centres were recruited purposively to maximise their heterogeneity and that of individuals involved with them. An inductive thematic approach to analysing qualitative data was taken.

Chapter 5 of this thesis presented detailed descriptions of the day centre case study sites and Chapter 6 the views of their managers and local authority employees. These contextualised the findings appearing in Chapters 7-9, namely the outcomes for attenders, carers, staff and volunteers. These findings are now summarised and then discussed.

10.2 Summary of main findings

The findings of this research extend the knowledge about generalist day centres for older people in an era in which care research has tended to focus on older people with dementia and their carers.

The first main finding is that day centres and their attenders, while sharing some characteristics, are not homogeneous; both are in a state of flux. The nature of day centres has changed and will, doubtless, continue to do so, particularly within a resource-constrained environment in which growing numbers of older people's physiological needs must be met. Centres have evolved from being larger communities of younger, more active older people to smaller communities of, mainly, housebound and 'vulnerable' (National Institute for Health and Care Excellence 2015) older people and, like extra care housing (Vallelly *et al.* 2006) and care homes (Lievesley *et al.* 2011), they now cater for increasing proportions of people with dementia. Thus, they are no longer the 'low-level' services they have previously been described as (e.g. Caiels *et al.* 2010). What has remained unchanged is their attendance by widowed/single people and people living alone. At the same time, they may be viewed as 'evolving communities' since their attenders are ageing and their health deteriorating in one place, together.

The second main finding is that contemporary day centres were a life-enriching gateway to companionship, activities, the outside world, practical support, information, other services, the community and enjoyment for socially isolated people who were unable to go out without support. Attenders and carers attributed quality of life improvements directly to their own or a relative's day centre attendance. Day centres have not previously been conceived academically as gateways or as sources of enjoyment. Centres acted as a community of choice that 'enabled' and

offset isolation at home or loss, in the absence of other suitable options, as well as promoting wellbeing in volunteers and providing job satisfaction for staff. Attending a centre, therefore, constituted inclusion and not separation. The continuity provided by a congregate environment was as integral to this point as it was to the next, that of added value.

The third main finding was that day centres offered added value beyond the purposes for which they were commissioned or funded, beyond what may be assumed to be covered by an aim of improving quality of life or supporting people to remain at home and beyond what attenders may have expected, given their reasons for attendance. This added value was fourfold. First, it lay in the unique wellbeing contribution centres made to the lives of their volunteers and staff. Second was the practical support and information centres provided in a supportive environment and the access to other services they facilitated, either at centres or elsewhere. Third was the health and wellbeing monitoring undertaken that benefited attenders, carers and signposters/referrers, and which was rendered possible by trusting relationships with, and providers' background knowledge of, individuals. Further research would be needed to determine any systemic benefits of such monitoring. Fourth, location in a shared community building provided additional advantages in several respects. These included perceived easier access to and greater acceptability of centres, greater availability of services or facilities that are likely not to have taken place or been made available at standalone centres – including serendipitous opportunities - and greater opportunities for community integration. These aspects of added value emphasise centres' underlying nature of being long-term maintenance and monitoring services rather than services that deliver specified improvements after which people are discharged. This, however, does not preclude fixed-term improvement interventions from taking place at day centres or attenders being referred to other services.

The fourth main finding is that day centres were not stigmatised and outdated relics of the past. Instead, their role is highly relevant to current social care and health policy themes but there is a lack of awareness of them among older people. Centres supported their mainly socially isolated and housebound attenders to age in place by focusing on their wellbeing and prevention of deterioration, and acted on any safeguarding or health concerns. They also promoted the wellbeing of their (younger) older volunteers and supported family carers of attenders. Experiences reported were mainly positive, in line with the expectations of the Outcomes Frameworks (Department of Health 2013), with a notable exception of the impact of increasing proportions who are cognitively impaired. Although partnership working with social care and health and with community and voluntary organisations was evident, this was variable. This and the lack of awareness of day centres among older people underpin the final finding.

The fifth, and final, main finding is that day centres were under-used resources with recognised potential for development that could maximise the impact of health and social care services on individuals, professionals and the system as a whole. The small group of local authority study participants' creative ideas for the future showed an understanding of the type of potential partnership working with other parts of social care and the NHS that would further develop their role as a community resource. Development would, of course be subject to environmental constraints. In maximising use of centre buildings, centres are likely to become more visible and 'accessible' in people's eyes.

These findings, which confirm the existing evidence base and add to it, are now discussed.

10.3 Day centres, their attenders and change

Assumptions of homogeneity, definitional inexactitude and between-country model differences may be among the factors accounting for the lack of descriptions in the published literature. This thesis has contributed to the knowledge detailed descriptions of four day centres in England, their operation and narrative accounts of their days using data gathered over four 14 week visit periods. These provide greater depth than other accounts (Tester 1989, Carter 1981, Salari *et al.* 2006, Lund and Englesrud 2008). Following Gubrium (1986) and Salari *et al.* (2006), centre buildings and layout are described. As in Gubrium (1986) and Smith and Cantley (1985), an entire chapter is dedicated to their description, providing detailed context to situate the study's other findings. These case studies highlight the differing nature of English day centres. However, their differences did not appear to affect local authority social care participants' perceptions of centres' role and purpose.

Given the lack of national data about English day centres (see 1.2), attender participants' characteristics cannot be benchmarked against an existing dataset. However, they broadly matched the tendency noted in the literature on day centres covering the period 2005-2017 for attenders to be female, older, living alone, widowed/divorced/single, with no more than secondary education, low income and with multiple health conditions (see 4.7.1), although there was a group of attenders ineligible for this study who had been nurses (type unknown) at one centre. Manthorpe and Moriarty (2014) observed the failure of literature to note the over-representation of women among attenders which this study found persisted. Women accounted for three-quarters of participants (and attenders overall), yet account for 60 per cent of people in England aged 80 and older and 55 per cent of people aged 68 and older (youngest study participant's age) (Office for National Statistics 2017).

Motivations for attendance confirmed those previously identified in the recent literature (2005-2017), namely wanting social contact (Iecovich and Biderman 2013a, Pardasani 2010, Marhankova 2014, Fulbright 2010), wanting to do something (Ingvaldsen and Balandin 2011, Lund and Englesrud 2008), wanting to improve wellbeing (Iecovich and Biderman 2013a) and for carer respite (Iecovich and Biderman 2013a). An additional motivation arising, feeling the need to get out of the house for a change of environment, did not appear in the recent literature. These, and other, studies have also reported participant characteristics (to a degree), but none have explored the circumstances behind these motivations or attenders' lives beyond their socio-demographic details.

This study has found that circumstances behind these motivations were, specifically, decreased mobility that was health-related or socially constructed due to having stopped driving, bereavement, living alone, closure of another service, stopping a volunteering role, retiring, having lost confidence, feeling low, lonely, depressed or being isolated as a carer. Thus, in contrast to the 2005-2017 literature, which reported overall that day centres were used by people whose health had begun to decline, this study found they were attended by people whose health and mobility had already declined due to loss (e.g. of health) or had resulted in loss (e.g. of social contact).

Earlier studies' findings were supplemented by this thesis' contextual data which showed a high proportion of attenders had a social network type that placed them at greater risk of isolation, depression, loneliness and other mental ill-health, and by discovering attenders' regular activities. Apart from a small number of studies investigating other services also used by attenders (e.g. Chen and Berkowitz 2012) but not their social network type, such contextual data are missing from the literature and are a unique contribution of this study.

Contrasting with participants in Caiels *et al.*'s relatively recent (2010) English study, 13 per cent of whom regularly volunteered, the few participants in this study who had been 'active citizens' had stopped such activity following their changed circumstances. Years beforehand, Gross and Caiden (2000) noted increasing disability among English day centre and lunch club users and Burch and Borland (2001) argued that the policy goal of encouraging ageing in place was responsible for frailer and more vulnerable older people using day centres. These changes matched managers' reports of changed physical and cognitive attender profiles compared with five years before data collection for this study (2015-16) (see 6.6.2). While many case study site attenders had grown older and frailer while attending their centres (as in Turner 2004), their health and functional independence were compromised before attendance. Further corroborating this finding was the exclusion from this study of 41 per cent of observed attenders due to cognitive limitations to such an extent that this affected their ability to engage with ASCOT's hypothetical questions and to map out their usual week or to consent to participate in this study (see 3.3.3). This proportion is double

the 19 per cent of publicly-funded day centre attenders with dementia reported in the 2013-14 annual survey of Councils with Adult Social Services Responsibilities (NHS Digital 2014) and is despite the study including older people not referred by a local authority and that some participants reportedly had a diagnosis of dementia but whose hypothetical thinking was not yet compromised. In the US, as far back as 1999-2000, Richardson *et al.* (2008) reported having underestimated numbers of people with dementia starting to attend non-profit day centres.

Thus, day centres appear to be evolving alongside changes in social care. Participants exhibited advanced age, declining health and mobility, sensory loss, bereavement and were retired, all of which are risk factors for social isolation (World Health Organization 2002), and many had social network types that placed them at risk of isolation, depression, loneliness and other mental illness (Wenger 1994, 1997). Attenders' profile - both before attending and during fieldwork - places them within NICE's category of 'vulnerable older people' who are '*most at risk of a decline in their independence and mental wellbeing*' (National Institute for Health and Care Excellence 2015:para 1.5.3). This group includes older people bereaved of their partner in the last two years, who live alone with little opportunity to socialise, are recently separated, divorced or retired, have developed a health problem, have given up driving, are on a low income, are aged 80 or older or who are carers. Despite being vulnerable (National Institute for Health and Care Excellence 2015), attenders were mostly without high levels of frailty. Certainly, this profile contrasts sharply with that of attenders in studies undertaken in the 1970s and 1980s, a greater proportion of whom was younger and more active (Carter 1981, Fennell 1981 cited in Tester 1989). During that period, publicly-funded social care eligibility criteria had not yet been tightened to exclude people with low and moderate needs, charges were not widespread and more 'low-level' day centres operated (Means *et al.* 2002, Tester 1989). It is worth noting that this study's participants did not include people with the highest needs (e.g. severe dementia or reliance on life-sustaining devices) since a sharp decline in health was said to cease attendance (Pardasani 2010). However, participants included wheelchair users (all centres were fully accessible), and there were high needs among a group of attenders at one centre including one who required PEG feeding (a tube inserted into the stomach through which people who are unable to swallow or eat or drink enough are fed and fluid is administered).

Day centres' financial support is also changing. Reviews of provision had been or were due to be undertaken in the case study site areas. Some local authority participants considered centres more relevant for people with dementia than other older people. There was also some desire to try to meet needs and preferences in alternative ways that were felt to be more linked with the policy of personalisation and its key tenets of choice and control. Permissions to fund attendance at day

centres were not all being approved by local authority panels in the context of substantial rationing of funds (Fernandez *et al.* 2013), and there had been internal guidance to curb such expenditure.

While this study found that centres are attended by vulnerable, and mostly housebound, older and cognitively impaired people whose needs were not high enough to require specialist day centre attendance, the state of flux highlighted means that Manthorpe and Moriarty's statement still holds:

'research will need to establish if the UK is currently witnessing a major disinvestment in day centres or whether this will turn out to be part of a shift to formal day centre support as a service designed to support people with very high support needs who are living at home and funded by personal budgets, their own funds or health service monies.' (Manthorpe and Moriarty 2014:359)

10.4 Day centres' effectiveness

The aims of participating day centres were consistent with the 2005-2017 literature which found that the four purposes of day centres were to provide social and preventive services, to support the attenders' continued independence, to support attenders' health and daily living needs and to enable family carers to have a break or continue with employment (see Chapter 4). The difference was in how aims were expressed, namely in relation to quality of life and wellbeing, with two centres placing aims within a framework of enabling attenders to remain at home. Acting as a resource for attenders, families and the local community also figured among one participating day centres' aims. The pre-1980s research mentioned a further aim, namely to offer an opportunity to get out of the house (Goldberg and Connelly 1982), which might be considered implicit in a goal to improve quality of life and reduce social isolation. Tester's (1989) study also identified objectives of assessment, rehabilitation and treatment, but her survey included day hospitals. Thus, contrary to Tester's (1989) finding, centres' aims were clearly defined, although some were more specific than others.

Participant characteristics indicate that centres' users matched their target groups in that they were attended by older people who were socially isolated and had transport needs, and, in two centres, personal care needs.

The outcomes for attenders arising from this research suggest that not only did the day centres in this study address attenders' own motivations for attending, but they surpassed these by enabling additional positive outcomes. In the main, outcomes of involvement with day centres also met day centres' aims. This study's findings showed that attendance had a positive effect on quality of life, which is a key outcome indicator used within social care and a policy goal, both for attenders and carers.

Outcomes for attenders, carers, staff and volunteers are discussed next within a framework of their contribution to wellbeing and health. There follows a discussion of centres' contribution to their attenders' independence.

10.5 Involvement with day centres as a life-enriching experience that supports wellbeing and health

This study found that involvement with a day centre, whether by attending one, being a carer of an attender or by volunteering or working at one, was a life-enriching experience that provided unique input to the lives of attenders, volunteers and staff. The findings that attending, volunteering or working at a day centre added something unique to people's lives goes beyond previous research, although some studies have investigated whether services made a difference to attenders' lives or an aspect of life (e.g. Caiels *et al.* 2010, Dabelko-Schoeny and King 2010, Fulbright 2010). Although the evidence of the benefits of volunteering has been reviewed (Jones *et al.* 2016, Jenkinson *et al.* 2013), the specific benefits of frontline volunteering in a day centre have not been drawn out despite the evidence that the greatest benefits for volunteers of volunteering are known to derive from 'hands-on' involvement (Casiday *et al.* 2008). Carers' and local authority employees' perceptions of the role and purpose of day centres did not include any impact on volunteers or staff which suggests that the benefits for these groups are under-recognised.

I will now discuss these unique contributions and other new, related findings.

Wellbeing is a multi-faceted concept, the promotion of which is a national policy priority that guides the funding and development of services in that '*the aim of social care is to improve the overall wellbeing of people with impairment and that of those who care for them*' (Netten 2011:

24). Wellbeing is comprehensively defined in the Care Act 2014 as relating to:

- (a) *personal dignity (including treatment of the individual with respect);*
 - (b) *physical and mental health and emotional well-being;*
 - (c) *protection from abuse and neglect;*
 - (d) *control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);*
 - (e) *participation in work, education, training or recreation;*
 - (f) *social and economic well-being;*
 - (g) *domestic, family and personal relationships;*
 - (h) *suitability of living accommodation;*
 - (i) *the individual's contribution to society.'*
- (HM Government 2014: Chapter 23, Part 1, 1.2, p2).

This study has identified outcomes of day centres in all of the above categories except (h) 'suitability of living accommodation'.

Wellbeing contributes to quality of life, also multi-dimensional (Sixsmith and Sixsmith 2008), and which is defined as '*incorporating in a complex way a person's physical health, psychological state,*

level of independence, social relationships, personal beliefs and relationship to salient features in the environment' (World Health Organization 1998:17). Clow and Aitchison's (2009) model

explains that wellbeing is important as its benefits are cyclic. Thus:

'positive well-being is not only an end-product (...) but has the power to promote motivational and cognitive characteristics in its own right. Thus, promoting positive well-being is a sustainable way of making a real impact on the lives of older adults. It is imperative to ensure those living longer are healthier as an end in itself and also in order to reduce the potential burden on the resources of the health and social services, families and communities in years to come.' (Clow and Aitchison 2009: 130).

Day centre attendance is reported to improve quality of life (Caiels *et al.* 2010, Ipsos MORI 2014), with attenders having a better quality of life compared with non-attenders in some samples (although causality could not be proven) (Iecovich and Biderman 2013b) or recipients of home-based services (Ron 2007), but not always (Schmitt *et al.* 2010). Time-limited interventions in day centres have improved physical and/or mental quality of life (see Chapter 4, e.g. Ota *et al.* 2014, Frosch *et al.* 2010), but not always (Mathieu 2008, Dickson *et al.* 2014, Morrisroe *et al.* 2014). This study's findings concerning quality of life and mental wellbeing concur with other recent studies in that centre attendance leaves people feeling more content (Fawcett 2014), more confident (Fawcett 2014) and more mentally stimulated or energised (Fawcett 2014, Ipsos MORI 2014), less depressed (Dabelko-Schoeny and King 2010, Santangelo *et al.* 2012, Bilotta *et al.* 2010, Wittich *et al.* 2014), less lonely (Aday *et al.* 2006), having gained a better perspective on their own abilities (Dabelko-Schoeny and King 2010), having a sense of belonging (Aday *et al.* 2006, Ron 2007), a sense of purpose and structure in their life (Ron 2007) and feeling in control (Ron 2007, Fawcett 2014, Caiels *et al.* 2010).

A new finding is that day centres made a major contribution to the mental wellbeing of their attenders who were all, following NICE's (2015) definition, 'vulnerable' and at risk of declining independence and wellbeing, by supplying a source of enjoyment or fun. Although people have been reported to enjoy attending centres and to laugh there, this has been conceived as contributing to overall life satisfaction (Aday *et al.* 2006, Tse and Howie 2005) and enjoyment of activities as contributing to whether attending has made a difference to people's lives (Dabelko-Schoeny and King 2010). Apart from the Bahranian model of centres referring to fun as an aim (Al-Dosseri *et al.* 2014), attention was not drawn to centre attendance as an enjoyable or fun activity in the 2005-2017 literature (see 4.3). Not only did participants in this study enjoy certain aspects of what was provided by centres, but many enjoyed the whole experience, looking forward to or loving it. Enjoyment, which was also experienced by staff and volunteers, significantly contributes to wellbeing (Haworth 2016) and laughter has a positive psychophysiological impact (Savage *et al.* 2017).

The overall contribution to wellbeing of attendance may also be set within Cattán's (2015) evidence-based model, according to which there are four key contributors to positive mental health and wellbeing which change over the life-course. These are functional ability, psychological attributes (including purposiveness), power and resources (including community facilities) and social connectedness. Day centre attendance potentially contributes to three of these by providing social connectedness, a sense of purpose and a community facility. It is possible that attenders' compromised functional ability, the fourth contributor, may have intensified the contribution of the other factors.

That day centres provide valued social contact is the most-documented outcome of day centre attendance (e.g. Powell and Roberts 2002, Turner 2004, Tse and Howie 2005, Aday *et al.* 2006, Caiels *et al.* 2010, Dabelko-Schoeny and King 2010, Goldberg and Connelly 1982) and is a finding of this study. Moreover, this study has found the improvement to quality of life resulting from social interaction to be more widespread compared with Caiels *et al.*'s (2010), the only other identified study using ASCOT in day centres, albeit an earlier version than that used in this study. As a similar proportion of participants in both studies lived alone, this difference perhaps reflects this study's older and less mobile participant profile, although functional performance levels are not precisely comparable. Also suggesting mobility may be behind such difference is Glass *et al.*'s (1999) finding that the strongest effects of social activities were amongst those least physically active. Thus, the impact of social participation was greater than previously suggested, which may reflect the contribution of relationships and interactions to wellbeing (Barnes *et al.* 2013).

It is interesting that companionship gained from attending centres was not at the level of intimate relationships (Carter 1981). Clearly, even low key social contact and participation were important (Barnes *et al.* 2013). Attenders may not have been looking to build intimate or meaningful relationships; rather they simply wanted to mix with people regularly. Companionship may have been a bonus for those attending for other reasons. Moreover, attenders reported to have made (close) friends or connections outside day centres had a more active profile or attended a senior centre/day club model (Aday *et al.* 2006, Fawcett 2014). Thus, this finding is more about companionship that supplemented deficient social networks rather than 'social capital' to draw upon practically. This said, reciprocity is one element of social capital, and the study's findings suggested that companionship also provided opportunities for reciprocity (Thompson 2016) which is highly valued (Allen and Wiles 2014), seen as crucial for independence (Gibson 1985), a way to maintain a balance when a certain level of independence has been lost (Tanner 2001) and is a contributor to wellbeing as defined by the Care Act 2014 (HM Government 2014: Chapter 23, Part 1, 1.2, p2).

Another enactment of reciprocity is volunteering (Bowers *et al.* 2011, Putnam 2000). A national survey found that older people were more likely to volunteer for organisations supporting older people or community groups (Low *et al.* 2007). Means *et al.* (2002:102) cited a 1980 local social services report that referred to volunteer-run lunch and social clubs as being run '*on a self-help basis.*' Not all volunteer study participants had started to volunteer for altruistic reasons, yet most reaped benefits, suggesting volunteering in day centres may be tantamount to self-help. Although this study identified mental wellbeing benefits for volunteers, Jenkinson *et al.* (2013) concluded, from their evidence review, that there was insufficient evidence of its mental health benefits to consider it a public health intervention.

New findings concerning volunteering or working in a day centre were fourfold. The first two concern its unique contribution to volunteers and staff's lives. First, day centre volunteering provided social connections that a few reported would otherwise have been absent. This confirms and adds depth to a review finding that the strongest evidence about volunteering in later life concerned improved social connections (Jones *et al.* 2016), and affirms that day centre volunteering may promote social inclusion (Tester 2001). Second, working at one gave access to older people which staff would not otherwise have had. Third, experiencing teamwork was one of the most-liked aspects of both volunteering and staff roles. Fourth, as well as being an enabler of relationship-building between co-attenders, the continuity, or regularity, of contact was one of staff's most-liked parts of their job, as building a relationship with those they supported enabled them to see the impact of their work. These findings are discussed in relation to continuity and workforce retention in 10.9.

Whereas in Caiels *et al.*'s (2010) study of English day centres, the next most common benefit after social participation concerned meals and their home cleanliness and comfort, this study has found it was in the domain of activities, or meaningful occupation. This thesis has also described activities undertaken in these day centres and their organisation, something previously only touched upon by a small number of more recent studies (Hostetler 2011, Boen *et al.* 2010, Lund and Englesrud 2008, Kuzuya *et al.* 2006, Wittich *et al.* 2014, Iecovich and Biderman 2013b). In 1970s England, providing company and a meal were day centre aims in themselves (Carter 1981) and organised activities were not part of a day centre's offer. By the 1980s, the most common activities were games, music, entertainment and discussions (Tester 1989). This research found that activities have evolved to include some with a therapeutic or rehabilitative nature although this was not always explicit. Activities included entertainment, interactive, group and solitary activities that were either informal or formally led (see Chapter 5 and 8.4.3). Despite being cognitively beneficial (Sobel 2001), bingo did not dominate. In most centres, activities were varied

although not all attenders' needs were catered for, and half were happy with the variety. Joining in these was said to be enjoyable, stimulating, and, in some cases, satisfying. Some attenders were more focused on simply having something, or something different, to do; others focused on the activities themselves which also offered the chance to engage informally with others (Dabelko-Schoeny and King 2010, Fitzpatrick *et al.* 2005).

That attending a day centre provided a way to access the outside world was an unsurprising outcome since a centre is a building to which people travel. Nevertheless, this was important since people leave their homes less with advancing age, with very old people spending an average of 80 per cent of their time at home (Baltes *et al.* 1999). Staying at home for most of the time due to health constraints is significantly associated with poor wellbeing (Holland *et al.* 2005), despite home's positive associations (Higgins 1989, Willcocks *et al.* 1987), and getting out is something older people with high support needs want to do and value (Katz *et al.* 2011). Doing so provides variety, some physical exercise and social interaction (Holland *et al.* 2005, Bowers *et al.* 2009). In focusing on the importance of remaining at home, it is possible that the importance of a change of environment for wellbeing is overlooked. Centres also linked their attenders with the outside world by organising day trips, inviting external speakers and activity leaders or entertainment, and through co-location with community facilities. Attenders also connected with the wider world at their centres by discussing current affairs or reading the news on tablet computers. One example in the literature reviewed in Chapter 4 was a philosophical discussion group that included members of the public (Gallagher 2016), but case study site activities did not invite members of the public to join activities.

This study adds to the limited evidence about outcomes for carers of older day centre attenders. On attendance days, centres fulfilled practical tasks and enabled carers in this study to have peace of mind. Services offering this type of 'replacement care' help carers stay in work rather than leave due to caring responsibilities (Pickard *et al.* 2017). Although this study found low overall quality of life gain attributable to centres, when measured by ASCOT, gain in the higher order domains of feeling supported and encouraged, occupation and control were higher (see 9.3). The relatively low gain experienced in the space and time to be yourself domain is perplexing since having free time was one of carers' most valued outcomes. One may speculate that it may be because few days were spent at centres, because few co-resided with attenders, or carers may have had other time-consuming responsibilities (i.e. partner and/or children, paid employment). Fleming and Taylor (2010) noted a lack of recognition for the carer support role of lower level preventive day services (for adults with physical and sensory disabilities) despite evidence for this. From local authority officer participants' responses, one may speculate that assumptions that it is less

burdensome to care for an older person without dementia (or with mild cognitive impairment) than someone with dementia may have led to a lack of recognition of centres' carer support role. Centres may wish to involve carers more to maximise the benefits for them and for their relatives. Notwithstanding this study's finding that day centres support carers for older attenders of generalist day centres, there remain many unanswered questions.

Having considered the stated unique contributions made by day centres, I now draw attention to two additional 'safety net' outcomes. The first is monitoring. In the 2005-2017 literature, centres' role in supporting health and independence mainly resulted from time-limited interventions to reduce symptoms or to prevent or delay deterioration caused by specific conditions (see Chapter 4). This study has highlighted how regular centre attendance, provider knowledge about attenders' circumstances, trusting relationships between attenders and providers and a supportive environment all combine to enable the monitoring of health and wellbeing, and that some local authority professionals recognise this as a role. It may be argued that this type of monitoring constitutes a personalised service. Not only did monitoring contribute to the maintenance of wellbeing and timely health checks, but it also supported family carers by legitimising any imagined worries and identified safeguarding concerns. Monitoring was argued to be beneficial for attenders by Kuzuya *et al.* (2006) and suggested to be a reason for lower hospital use, and shorter hospital stays by Kelly (2017). It is possible that combining monitoring with being part of a day centre 'community' may contribute to the prevention of self-neglect (May-Chahal and Antrobus 2012) since attendance made a difference to some in the ASCOT personal care domain. Although undertaking monitoring may be implied by centres' aims, greater recognition of this as a role, together with its contribution to the potential saving of health or social care resources elsewhere (e.g. hospital beds or care home places) may be beneficial for day centres with respect to the potential for joint health and social care commissioning. However, this study did not collect data specific to this activity and further investigation would be necessary to unfold its extent and impact. The second safety net outcome is access to practical support, information and other services. Within the context of prevention, importance has been placed on single entry points (Robertson 2008) to minimise people 'falling through' gaps between services. It is likely that the supportive environment in centres facilitated practical support (e.g. helping with letters and appointments) which relieved attenders of the undesirable need to burden family with requests (Lewinter 2003).

It is notable that the outcomes discussed above were achieved despite three-quarters of participating attenders using centres for only one or two days a week (i.e. 4.5-12 hours excluding travelling time). This may be attributable to the fact that many outcomes for attenders and carers

fall within the higher order categories of human need, namely social belonging, esteem and self-actualisation (Maslow 1943), that is, they concerned feelings and mental wellbeing.

Although ASCOT INT4 was easy to administer and effective for isolating and demonstrating service effect, particularly for intangible outcomes that are difficult to evidence, this study has highlighted how details concerning services, which may be useful for providers, are better drawn out using qualitative methods (Willis *et al.* 2016).

Having discussed relevance of day centres' outcomes to the policy priorities of promoting wellbeing and delaying deterioration and the added value they offer, I now discuss participants' varying perceptions and the definition of day centres.

10.6 Perceptions and reported realities

In 3.1.2, I stated an expectation that qualitative and quantitative investigation of outcomes for attenders may corroborate and complement each other, which I have reported they did. I also highlighted an expectation that 'multiple realities' may emerge from participant groups' perspectives on outcomes attenders gained. In fact, perceptions of other participant groups' outcomes often converged with realities as reported by attenders, although there were between-group differences. Although outcomes for older people were mainly understood, there was a lack of recognition of their link with policy themes. The 'bigger picture' of any contribution attendance may make to supporting people to remain at home was cited by only a minority, yet an overarching policy goal is to support people to age in place. There was low recognition among local authority participants of outcomes for carers and no recognition of any potential benefits for centres' staff and volunteers. Although one may expect the latter, the former is surprising since a long-standing aim of centres has been carer support. This may suggest that greater importance is placed on support for carers of people with dementia and that the need to support carers of older people more generally is under-recognised.

10.7 Day centres re-defined?

The definition of day centres for this thesis, as community building-based services that provide care and/or health-related services and/or activities specifically for older people who are disabled and/or in need, which people can attend for a whole day or part of a day, is upheld by the aims of the case study day centres and this study's findings. I debated whether an additional target user group, namely vulnerable older people as defined by NICE (2015), should be added since this describes centre attenders. Doing so would broaden the original definition since 'vulnerable' includes older people (and carers) who may not yet be disabled or in need, but this would not reflect the reality. Furthermore, vulnerable people who are not yet disabled and/or in need would

be precluded from attending centres accepting local authority referrals only since people must already have needs to qualify for services.

10.8 Day centres: disempowering and stigmatised?

In line with expectations of national Outcomes Frameworks (Department of Health 2013), a majority of positive experiences were reported.

Case study day centres did not conform to the denigrating portrayals of centres as partial institutions (Townsend 1981, Salari 2002, Higgins 1989) which undermine self-identity (Goffman 1961), create and reinforce dependency via their structures (Townsend 1981) and provide care to passive recipients (Townsend 1981). Far from disempowering attenders and undermining their identity, attendance made unique and positive contributions to most attenders' lives, with one of the biggest differences being to their personal sense of significance, and high proportions enjoying attending them, looking forward to going and considering they were getting good value for money. Dependency was more about some attenders not knowing how they might cope without their day centre than disempowerment.

Satisfaction with, feelings about and outcomes of a service are a function of service quality, that is the way in which a service is delivered (Qureshi *et al.* 1998, Kajonius and Kazemi 2016). This study has confirmed Glendinning *et al.*'s (2008:61) assertion that '*day centres could provide excellent quality services, with a high emphasis on process outcomes*'. It has confirmed the importance of respect from (de São José *et al.* 2016), good relationships with (Dabelko-Schoeny and King 2010) and empowerment (Fawcett 2014) by staff which are key to 'good care' (de São José *et al.* 2016). Attenders reported that care and support were provided in a kind, helpful, friendly and enabling way by people with whom they had built a relationship, with the power dynamic in the hands of attenders. They were not passive care recipients (Weicht 2013), or seen as such (Bowers *et al.* 2011) by service providers, but exercised decisional autonomy (Söderberg *et al.* 2013), with most making active choices within their centres, whether about seating arrangements, meals, occupation or whether to discuss any concerns with staff or volunteers, for example. Having decisional autonomy impacts positively on mental health (Boyle 2005). Feeling in control is noted to be highly desirable and to significantly influence experiences (Glendinning 2008); having no control in one's life was rated as being equivalent to death in ASCOT's preference weightings process (Netten *et al.* 2012). Unlike home care recipients in Francis and Netten's (2004) research, participants in this study were assertively appreciative and knew how to deal with problems. In line with Sheikh *et al.*'s (2012) finding, a few would have stopped attending if unhappy with service quality. Attenders had not been coerced into attending nor were forced to stay. It is arguable that

choice was only at the start for those who attended as part of a care package, although regular reviews offered opportunities for change, albeit potentially limited by finances.

Neither were centres 'desolate places' (Cottam 2009) that perpetuated social isolation in a different setting '*out of normal community life*' (Tester 1989:168). Rather, attenders gained access to supportive and friendly environments in which they felt welcomed and valued and in which they engaged with people and in activities. For a few, centres were like a 'second home' (Ingvaldsen and Balandin 2011, Lund and Englesrud 2008). Many had wanted a change of scene. Not only this, but their health and wellbeing were monitored and they gained access to other services, practical support and information. Another perspective is that, prior to attendance, people's restricted mobility limited their out-of-home activities meaning they were already 'out of normal community life'. Thus, attending a day centre enabled them to be part of a specific community in the absence of another option, thus replacing some of what had been discontinued, and this was a satisfactory alternative. Such alternative may also be argued to supplement any other support received, if any, thus serving a maintenance function for people ageing in place with compromised mobility. Centres were also places in which staff enjoyed their work and places which provided social participation for volunteers and improved their wellbeing. In doing so, they provided an opportunity for volunteers to actively age, defined by the World Health Organization as '*a process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age*' (World Health Organization 2002).

Local authority participants in this study highlighted one centre's location in a multi-purpose building as both a USP and offering added value in several respects, not least since it contributed to normalising day centres by increasing their visibility. This concurs with Tester's (1989) conclusion, from her English year-long study, that day centres might be less stigmatised if located in buildings used by the general public. Yet it was only centre managers who drew attention to the benefits of location in a church and an extra care building. Since all four centres in this study had some level of connection with the wider community (see 10.5), albeit extremely varied and an area for development, I argue that centres did not perpetuate social isolation away from the wider 'community'.

Stigma resulting from centres' association with welfare (Tester 1989, Ingvaldsen and Balandin 2011), the use of which has been associated with poverty and involves declaring oneself deficient in some way (Titmuss 1968), is said to be more common among the older old (Lymbery and Postle 2015). While there was some recognition among all participant groups that day centres were not to everyone's taste, this study has found that perceptions of stigma prevailed over evidence of it. For example, attenders did not comment upon the term 'day centre', but some other participant

groups considered this term to be potentially off-putting (Sanders *et al.* 2009). While negative preconceptions were mainly in the older ages and positive ones among those aged 83 years or younger, ignorance and knowledge of day centres were at similar levels across age groups.

Of course, participants were those who had chosen to attend centres and those who had tried them and decided to stay, and it is likely that those who most attached stigma to centres or welfare may have rejected this option. Negative perceptions held by some participants were mainly unrelated to stigma. Delay between finding out about a day centre and acting on the information perhaps reflected an underlying, but unstated, attitudinal barrier (Ingvaldsen and Balandin 2011), a desire to remain independent or a lack of understanding of what the service entailed (Phillips *et al.* 2000), or indicated lack of readiness to fully acknowledge their support needs. According to carers in paid employment, older people are sometimes reluctant to use formal services (Yeandle *et al.* 2007). Indeed, a decision to attend may represent strategic action by people who have recognised their own needs and limitations and the implications of these, as for with housing options (Peace *et al.* 2011).

Unlike the male participants in Davidson *et al.*'s (2003) study, men were not particularly negative although a wish for more male attenders was expressed. Neither were activities universally condemned for being feminised as they were by male participants in Ruxton's (2006) service review. Unlike participants in Lund and Englesrud's (2008) study, attenders did not fear seeing people who reminded them of their own ageing. Instead, following Festinger's (1954) social comparison theory of self-enhancement and the concept of downward comparison (Wills 1981), seeing people worse off than themselves helped them to gain a better perspective on their own situation (Wills 1981), thus improving their subjective wellbeing.

That any negative views participants held were overturned after starting to attend (Sale 2006, Lund and Englesrud 2008) suggests that the lack of clarity concerning what a day centre was and why one would be beneficial noted by Tester (1989) remained evident. This and the widespread previous ignorance of day centres among attenders suggests a need for marketing centres to individuals as well as professionals to clarify their roles and purposes for different target audiences. English providers are reported to be aware of this need (Sheikh *et al.* 2012). The few studies reporting the views of centre managers in the US also noted the importance of marketing (Sanders *et al.* 2009), particularly critical in an environment in which choice was emphasised (Hostetler 2011). It appears that attenders previously unaware of day centres have been 'buying blind' which, perhaps, infers high levels of trust in providers or people who signpost or refer them to centres. That attenders of DCV1 and DCV2 used the provider organisation's name when referring to centres in interviews, whereas attenders of DCLA and DCHA used the names of centres

themselves, may have reflected their prior knowledge of providers' brands and other services they operated, but this is speculation. Marketing may take a Features, Benefits, Advantages (FAB) approach (Blythe 2005) which addresses each target user group's potential reasons for interest and outcomes, for which providers would need to view their centre as a marketable product.

The above said, not all attenders were happy all the time (see 8.4 and 8.5). Still, the gain from attendance appeared to outweigh the few negatives arising since people still attended regularly in spite of the unwelcome numbers of cognitively impaired co-attenders, overall small numbers, difficulties with sensory impairments, and the few activity options and a degree of inflexibility complained about by a minority. The lateness of transport's appearance among attenders' least favourite things, perhaps, indicates how strongly this contributed to their experiences given their dependence on it to get to their centres. Transport was a factor that Katz *et al.*'s (2011) review of the literature found to hinder or help the achievement of what older people with high support 4 needs wanted and valued. This underlines the importance of transport being available for centre attenders, despite this not being commissioned as part of day centre services. Some of what Katz *et al.* (2011) found older people wanted and valued were also outcomes of the day centres in this study: social interaction, making a contribution, control, independence, self-esteem, humour, mental health (including a sense of purpose), safety, getting out and about, physical activities, continuity and good relationships with carers.

What was potentially disempowering – although not necessarily perceived as such - was the apparent insufficient attention paid to ensuring that people are aware of the amount and administration of their personal budgets. This, however, was the responsibility of social services staff and was out of day centres' control.

10.9 Congregate versus individual support

Narratives have repeatedly referred to the (in)appropriateness of group services in a modernised environment (see 2.2), and Section 6.4 reports how local authority commissioner participants also tended to consider them irrelevant to the policy theme of personalisation. Publicly-funded, collective and traditional building-based services, such as day centres (Cottam 2009, Duffy 2010) are purportedly '*insufficiently attuned to individual needs and wishes*' (Barnes 2011:164). Yet individualising services, rather than personalising them, when group services may be preferred, equates to retaining a Professional Gift Model whereby individuals lack choice. It imposes the values of those holding power on '*what constitutes quality of life*' for the most vulnerable, undermining '*the actual and potential value of collective provision*' (Barnes 2011:164) and leading to '*enforced individualism*' (Roulstone and Morgan 2009:334) which may, or may not, meet individual

needs. Thus, concerns have been expressed that personalisation may '*lead to under-emphasis on the social and collective, as opposed to individual, outcomes of social care*' (Rees *et al.* 2012:8).

This study found the collective to be core to several outcomes.

Creativity in care and support planning (Newbrunner *et al.* 2011) and the use of individual support and community facilities (the use of which does not depend on having eligible social care needs) (HM Government 2014) are encouraged. Even with individual support, getting 'out and about' would be challenging given participants' disabilities, which some attenders mentioned. Partaking of community resources may be problematic or demoralising given attenders' characteristics (e.g. deafness, needing help to stand up). Nevertheless, choice is at the heart of policy and this study's participants had chosen a traditional group service to support their ageing in place. There are likely to be several reasons for this. While some older people prefer, and are able to undertake, accompanied journeys or outings (Wood 2010, Slay 2012), others may prefer day centres (Wood 2010, Sheikh *et al.* 2012) which usually provide door-to-door transport, on-site support and care. Some participants mentioned enjoying being looked after as they managed everything by themselves at home. Alternatively, centre use may result from ignorance of other options and inability to discover these.

The recurring theme of continuity, among attenders, staff and volunteers, provides an insight into both the value placed on it and its utility in services. Continuity was important for relationship-building with co-attenders, between staff and volunteers and between staff or volunteers and attenders. These relationships enabled attenders, for example, to enjoy interacting, to have an opportunity to contribute or belong, to feel safe or to look forward to the next attendance day. Consistency and continuity of staff are what older people have been reported to want in services (Katz *et al.* 2011). While it is possible to have continuity of support in individually delivered and consumed services, especially if privately-purchased, these do not afford the additional opportunities provided by group settings which, in themselves, contributed to positive outcomes of day centre attendance (Ron 2007, Fitzpatrick 2010, Dabelko-Schoeny and King 2010, Fawcett 2014, Iecovich and Biderman 2013a, Ingvaldsen and Balandin 2011, Lund and Englesrud 2008) and some interventions in them (Frosch *et al.* 2010, Gallagher 2016, Kogan *et al.* 2013).

It is worth noting the inherent risk of institutionalisation or disregarding people's individuality, or individual choices, when services are provided to groups of people. Yet, it would be difficult to attend to people's preferences and needs, promote wellbeing, prevent deterioration or signpost to other services without focusing on the individual, something case study providers clearly did since one of the highest ASCOT domains of quality of life gain was for personal sense of significance. Indeed, having built a service user-staff relationship is '*consistently proven to put*

service users more at ease. It also allows carers to become familiar with service users' preferences (as well as what they do not like), which helps to embed personalised care' (ekosgen 2013:iii). In this study, this also applies to the user-volunteer relationship. Attenders' process outcomes suggest that staff and volunteers in case study sites demonstrated good practice in being aware of their behaviour with regard to individual choices. Not all centres, however, acted on their knowledge of individuals' needs (e.g. sensory impairments); the reasons for this were not investigated.

This study found that staff derived job satisfaction from continuity which also facilitated their health and wellbeing monitoring role. Organisational benefits of continuity, in terms of staff retention, may merit further investigation. Low staff turnover leads to financial efficiencies, better teamwork and a well-trained staff body who know their clients and their needs, preferences, dislikes and interests well (ekosgen 2013). Hussein *et al.*'s (2016) longitudinal analysis of NMDS-DC data found lower care worker vacancy and turnover rates across adult day care than in home care and care homes. At 8.7 years, staff participants' average length of time in role was just over the 8.4 years reported by the National Minimum Dataset for Social Care (NMDS-SC, the largest national social care data set available in England) for people in the roles of (senior) care worker, activity coordination and other direct care-providing roles in day centres for all categories of older people (Skills for Care 2017), but this includes staff of specialist centres for people with dementia. This compares favourably with an average of 3.5 years for domiciliary care roles. Due to its lack of full workforce coverage, the NMDS-DC is not likely to be fully representative of day centres targeted at people outside national eligibility criteria for publicly-funded social care. Given the small sample, it would be too bold a claim to state that day centre staff remain in their jobs for longer than other social care staff, thus affording benefits of continuity for both employers and attenders (ekosgen 2013), but there were reports of lengthy stays being linked with job satisfaction.

10.10 Day centres: supporting ageing in place?

There is acknowledgement that remaining at home and remaining independent have become synonymous (Hillcoat-Nallétamby 2014) and the policy goal of supporting people to remain at home is sometimes phrased as supporting independence. Building on evidence collected for its guideline on independence and wellbeing (Cattan 2015), NICE defined independence as *'the ability to make choices and to exercise control over your life. This includes being able to live independently with or without support'* (National Institute for Health and Care Excellence 2015:39). This conceptualisation of 'independence' focuses not on disability or lack of functional ability but on the ability to have choice, control and equal access to opportunities, including about any practical assistance that is needed (Moulin 2008, Disability Rights Commission 2002, Morris 2011).

Whereas, in the 2005-2017 literature (see 4.5.2), centres' role in supporting independence often pertained to delaying institutionalisation or the maintenance of physical function, this study has found that centre attendance led to feelings of control and independence.

Attender participants did not explicitly state that their day centres supported them to remain at home. Nonetheless, the findings of this thesis (discussed earlier in this chapter) indicate that day centres, for their attenders, counterbalance some of the potentially undesirable consequences of ageing in place with mobility restrictions and improve quality of life. Just as people were physically and socially isolated in Goffman's (1961) total institutions, people finding themselves '*stuck in place*' (Lehning *et al.* 2017:159) may also be:

'Equally, an old person at home (...) may be quite as isolated, both socially and physically, as her counterpart in a long-stay institution. Indeed one of the great difficulties for both carer and cared for is the dulling monotony of a routine which is harsh, unrelenting and never changing and which allows no opportunity to meet new people or to see new places.' (Higgins 1989:13)

Despite their long history, or maybe because of it, day centres' current 'systemic role' does not appear to be clearly understood. Perhaps contributing to this is England's lack of a clear 'continuum' of care as operates in some other countries (e.g. Pardasani 2010, Kuzuya *et al.* 2012, Boen *et al.* 2010, Liu *et al.* 2015, Kelly 2017). Yet, given their outcomes for attenders and carers, day centres' may have a place within the 'mosaic' of health and social care in spite of not being altogether recognised as policy-relevant services. I use the term mosaic because Higgins' (1989) discussion of the notion of a 'continuum' of care suggests this term misrepresents the overlap of informal and formal care, particularly since there is no 'path' in terms of location of care in England. Higgins also distinguished 'support services', such as day centres, from care delivered in a residential home or at home, by describing it as '*care given **from** home where the person in need may travel from his/her place of residence to daily activities*' (Higgins 1989:5). The findings of this study suggest that there may be a need for local authority care and support planning to better consider centre attendance within the context of any other formal or informal support received and people's usual weeks.

The potential for closer working by day centres with the NHS was also identified by this study. This is discussed next.

10.11 Multifunctional buildings

As well as functioning as a locus in which to regularly gather, engage in activities and be cared for and supported by a trusted group of individuals, the findings suggest that there is potential for day centres to be developed. Day centres were under-used by individuals, by social services (adult services) and by health services. There were unfilled vacancies in all four sites. Some centres had

facilities that were under-used and may have been suitable for use by visiting social care or health professionals. Attender participants' low awareness of day centres prior to attending them and the need for marketing to both self-funding older people without and with assessed social care needs were raised in 10.8 and 10.9. Lack of referrals being received from social services appeared to be, at least partly, linked with financial constraints and decisions taken at senior level in social services departments that counteracted the service choices older people have made during care and support planning (Stevens *et al.* 2011); some participants reported applications for funding in respect of older people as part of care packages which were sometimes rejected but for unclear reasons. This is important because, as mentioned in 10.9, some older people would like to attend day centres (Wood 2010, Sheikh *et al.* 2012). Furthermore, there was clear enthusiasm by professionals for their potential to be exploited as a convenient community venue for NHS and social care outreach activities, such as clinics, something hitherto apparently relatively uncommon and, reportedly, challenging to arrange (see 6.6.5). 'Interventions' in case study centres were mainly limited to the social contact and their activity programmes which did not usually include time-limited programmes with specific health-related aims. Yet many examples of the latter and of partnership working with other agencies with good outcomes for attenders, and some with additional benefits for health services, appeared in the published 2005-2017 literature (e.g. Vogel *et al.* 2007 - working with Public Health, Truncali *et al.* 2010 and Resnick *et al.* 2012 - blood pressure monitoring). There are limitations to this assumption about case study centre activities as this study did not investigate reasons for offering certain activities that may be categorised as therapeutic (e.g. memory stimulation).

A think piece about the need for English day centres to re-invent themselves to survive rang true in that *'for some social care professionals and service users alike, day centres offer the ideal opportunity to provide targeted services to clients in a safe, stable environment'* (Sale 2005:30). Indeed, attenders in this study did mention the utility of accessing other services at centres, but suggestions were limited to chiropody. Providing a wider range of interventions or clinics at day centres, as suggested by local authority participants in this study, may help keep more mobile attenders healthy and active for longer (Wick 2012) and may be more convenient for people with multiple morbidities who attend several clinics, as well as more efficient for the clinics (Salisbury *et al.* 2011). For such developments to be successful, sufficient attenders will need to be present; falling numbers may present difficulties. In the case of Burch and Borland's (2001) English randomised control trial of rehabilitation with visiting physiotherapists and healthcare assistants, in a day hospital and a social services day centre, health and social care cultural differences, a lack suitable facilities and negative perceptions on the part of some professionals and potential

beneficiaries were hindrances. They concluded, however, that day centres, with health input, had the capacity to provide successful rehabilitation.

What was not mentioned by local authority study participants, but which one manager did mention, was the potential for developing a multipurpose (or continuum style) model such as those in the US described by Taylor-Harris and Zhan (2011). These catered for active, semi-active older people and older people needing support and offered facilities such as a swimming pool, a weights room, cinema, television room, computer room, space for classes, a café and a day centre. Some of the active older people volunteered in other sections which, perhaps may have lessened any stigma they may otherwise have felt since they would have been simply moving through the continuum of support in a familiar building. This is the type of model that US baby boomers indicated they would be happy to use (MaloneBeach and Langeland 2011). The most similar model in England seems to have been centres funded by the Government Healthy Living Centres programme using lottery funds (Hills *et al.* 2007). These were run in partnership across statutory, voluntary, community and private sectors and offered targeted and mainstream programmes of activities to meet local needs; some were targeted at older people. This programme's final report stated that an evaluation of one such centre found wellbeing improvements in its regular older users (when measured with a validated tool), reduced visits to health professionals and reduced prescriptions. Since people with long-term conditions account for half of all GP appointments (Hobbs *et al.* 2015), this would suggest this model's potential for considerable reduction in pressure on the health service. It will be important for any multipurpose building planning to take account of, for example, continence considerations; 'accidents' on fabric chairs needed attention in three case study sites.

Arising from this study was also the potential for day centres to feature on social prescriptions. Practice guidance describes a social prescription as a non-medical intervention whereby primary care professionals (NHS) make a referral to local non-clinical services with a goal of promoting improved outcomes for people with social, emotional or practical needs (Friedli *et al.* 2008). Outcomes of social prescriptions include improved self-esteem, mood, self-efficacy and confidence as well as social opportunities (Friedli *et al.* 2008, Brandling and House 2009). Social prescriptions essentially conceptualise a service prescribed as a 'remedy' for people with poor mental health or as an intervention for 'vulnerable' older people as defined by National Institute for Health and Care Excellence (2015) and, potentially, also for volunteers. In subscribing to this conceptualisation of day centres as a 'health' service as well as a social service, there are several risks. The appearance of day centres on such prescriptions may be limited by the challenges of developing relationships with GPs. It may further hinder progress in moving away from the medicalisation of

old age (Estes and Binney 1989). Medicalisation of day centres may lead to a deviation in their focus. An emerging perception that they are 'day health centres' may result in the exclusion of people without the highest needs due to gate-keeping and limited financial resources. More positively, if day centres were to be re-conceptualised as part of both the 'care and support' and the 'health and wellbeing' systems, this may be a small step towards integration and advantageous for open access centres without stable or consistent funding whose numbers have reduced. Encouragement of centres' use in social prescriptions might also be linked with the debate about efficient use of health and social care finances since wellbeing is one aspect of health. It may also foster the aforementioned development of clinics at day centres, or encourage the development of Healthy Living Centre style facilities. Integration or partnership working is a current (2017) policy theme and something that has been behind initiatives as far back as the Section 31 Health Act 1999 flexibilities which allowed budget pooling, joint commissioning and integrated provision (HM Government 1999). Although partnership working between health and social care has been a long-standing objective, it is also an acknowledged challenge (Dickinson *et al.* 2012, Cameron *et al.* 2015).

Another finding of this mixed methods study is that qualitative and quantitative findings confirm each other, with insights into additional outcomes and experiences emerging from its qualitative findings. This is noteworthy as a dominant bio-medical model of evidence generation prevails, and qualitative research is often downgraded in importance (Glasby and Beresford 2006). It is also problematic for the commissioning and development of heterogeneous services, such as day centres, that the evidence base for preventive services is under-developed (Allen and Miller 2013) since commissioning is intended to be evidence-based (Local Government Association 2015). Furthermore, signposters/referrers had no access to research evidence of centres' impact which may have weakened requests for centre attendance put forward for internal management approval. A shift in thinking of robustly designed qualitative research as systematic scientific evaluation may assist evidence about social care services to be generated.

The following chapter closes this thesis by setting out the originality of its findings and their significance, the study's strengths and limitations, some reflections on the research, implications of this study, recommendations for research and conclusions.

Chapter 11 Conclusions, implications for policymakers and practice and recommendations for research

In this final chapter, I highlight the original contribution of this study to the body of evidence about social care for older people and those supporting them and explain the significance of its findings. Next, I summarise the strengths and limitations of this study and offer some personal reflections on the methodology, fieldwork, ethical concerns and the topic itself. I then state implications for policymakers and practice and recommendations for research, about which the Study Advisory Group and case study site representatives attending a workshop were consulted. Finally, I set out my conclusions.

This chapter is written in full acknowledgement of the continuously changing context of the current discussion, with further change expected. Not only was a Social Care Green Paper announced earlier in 2017, but five-year Sustainability and Transformation Plans (STPs) are newly in place, replacing Clinical Commissioning Groups, aiming to improve local integration of health and social care services (NHS England undated).

11.1 Original contribution of this research

This study has addressed identified gaps in the evidence and produced valuable new data. In terms of its originality and contribution, this thesis paints, from multiple perspectives, an in-depth, rich and contemporary picture of day centres for older people, ‘what’ they offer, who uses them, why, how and what they contribute to the lives of those involved in them, how they are perceived and their relationships with health and care services. In doing so, it has dedicated a full chapter to describing the case study centres. This presents details that are lacking from other contemporary discussions of the day centre sector. By providing data about the operation of four day centres and one day at each, this thesis has considered the day centre as one single service rather than as a series of interventions. Likewise, incorporating multiple perspectives, which few studies have done, has generated a rounded representation of four day centres and those involved in them, portraying the zeitgeist of 2015-16, and adding to the limited evidence about older people’s experiences and views on their social care services (de São José *et al.* 2016). Furthermore, it has updated the outdated English evidence base about centres that do not specialise in the care of older people with dementia.

Setting the study within a policy framework renders findings more pertinent to current contexts and enables better contribution to current debates. New understandings have been gained of what are ‘the outcomes that matter’ for those who attend, carers and other potential

beneficiaries, including the volunteers and staff involved in them, and how day centres may contribute towards their achievement.

Although not all the evidence ensuing from this study is new, the interpretation that day centres may function as gateways is novel, since centres have tended to be viewed, for example, more as services that reduce social exclusion or offer stimulating activities or carer respite.

11.2 The significance of these findings

This research has strengthened the evidence about the outcomes of day centres and demonstrated that qualitative research may be robustly designed to produce valuable evidence. It has several practical applications. The findings will be useful for providers reviewing their day centres and considering ways to measure service impact, may also contribute to informing professionals' decision-making concerning funding and approval of referrals, and will serve as a base for future studies.

Day centres have demonstrated their policy-relevance, and that they enhanced the quality of life of and made a unique contribution to their attenders' lives. Centres in this study provided their attenders what older people with high support needs have said they valued: social interaction, being able to make a contribution, control, independence, continuity, self-esteem, humour, mental health (including a sense of purpose), safety, getting out and about and physical activities (Katz *et al.* 2011). Yet day centres are being decommissioned (ADASS 2011), fewer publicly-funded older people are in receipt of local authority support (Ismail *et al.* 2014, Fernandez *et al.* 2013) and emphasis is being placed on enabling older people to participate in universally-accessible community services which may not be appropriate for mobility-restricted older people such as the attender participants of this study.

I have noted that attenders were mostly widowed, single, living alone, with multiple health conditions and that the profile of the attender population was older and with higher needs compared with five years previously. Analysis of data from the English Longitudinal Study of Ageing (ELSA) shows that the two biggest risk factors associated with chronic loneliness were being in poor health and being widowed and living alone (Iparraguirre 2016). There are rising numbers of older people living alone (Kempton and Tomlin 2014). The negative health impacts of social isolation or insufficient social relationships (Holt-Lunstad *et al.* 2010) and the association of depression with worse physical health (Stewart and Hirani 2010) have been documented. Furthermore, while many older people are not frail, frailty is more prevalent at older ages (65% of those aged 90 or older have frailty compared with 10% of those aged 65 or older) (Gale *et al.* 2015). The 85 and older age group is characterised by declining physical health, reduced capacity

to maintain a social life and increased contact with the health and care professions (Lloyd *et al.* 2014). Access to car or public transport is lower among those aged 85 or older than younger populations (Serra *et al.* 2011) and the prevalence of physical disability in this older age group limits ability to use public transport even if it is accessible (Department for Transport, Local Government and the Regions 2001). Key and Culliney's (2016) analysis of ELSA data found that age was the most significant factor influencing social exclusion; housing tenure was linked but not significantly. Even taking into account declining health, people aged 85 and older were at greater risk of social exclusion than younger older people. The age at which the likelihood of having mobility problems increased was 90 years. Key and Culliney concluded that a key population to focus on over the next 10-20 years is those aged 90 or older. While this thesis does not suggest that day centres should restrict themselves to being a service specifically for the older old, this paragraph highlights this group's 'vulnerability' to declining wellbeing and independence.

One may expect the ageing of day centres' attenders to continue given Public Health England's (2016) announcement that many people aged 65 years could expect to live until 85. Numbers of centenarians are growing, albeit overall numbers are still relatively small (Serra *et al.* 2011).

Day centres emerged as a community resource in several aspects. As well as addressing higher order needs, day centres offered practical benefits, access to other services and health monitoring that may become increasingly important in an environment with reduced family availability. Numbers of people ageing without children are rising (Office for National Statistics 2014), more people are ageing with disabilities without a spouse or partner who may provide care or support (Pickard 2015) and, for those who have had children, demand for care is projected to outstrip supply (Pickard *et al.* 2012, Pickard *et al.* 2007). Children and spouses or partners are the two groups of people providing most informal care (Pickard *et al.* 2007). The pool of potential informal carers is further reduced in the oldest old since many are childless, have no siblings and are separated, widowed or never-married (Tomassini 2005). Out-of-home supplementary care and support services may be highly valued as counteracting both the isolation of living at home (Phillips *et al.* 2010, Sixsmith and Sixsmith 2008, Higgins 1989) and the inability to get out freely even if not isolated. Not all older people who may wish to attend a day centre, including this study's participants, receive home care visits, which cater for physiological or environmental needs; even these are becoming increasingly shorter (Unison 2014).

More older people are living without dementia than with it, yet there is often a focus on supporting people with dementia and their carers. According to Prince *et al.* (2014), 7.1 per cent of people aged 65 and older and 20 per cent of people aged 85 and older in the UK have dementia. This means that 80 per cent of the older old are not living with dementia. If its prevalence is lower

in younger cohorts (Matthews *et al.* 2013) and its projected lower incidence (Ahmadi-Abhari *et al.* 2017) continues, even more than 80 per cent of the older old will not have dementia. While acknowledging the importance of services for people with dementia and their carers, there is also a need to ensure that the psychosocial (i.e. higher order) needs of those without it are not neglected, particularly when they are unable to leave their home without support, especially given the demographic context outlined above.

Turning to resources, concern about expansion (Lloyd *et al.* 2014) or compression (Howse 2006) of morbidity has been expressed, since both scenarios imply increased health spending which, on average, is three times higher for a person aged 85 or older than one aged 65-74 (Cracknell 2010). A health or wellbeing decline may go unnoticed or may not be as readily addressed by a person who is isolated and who lacks people with whom to discuss these, and may result in a resource-heavy health crisis. The fact that younger older people improved their wellbeing and built their social networks by volunteering, something important for the future given the situation outlined above, demonstrates that the principles of active ageing (with respect to day centres' contribution to maximising health, wellbeing, functioning health and independence and making a contribution) are as applicable to volunteers as they are to attenders. Lloyd *et al.* (2014:329) pointed out that, because active ageing delays the onset of disease and reduces health expenditure, responsibility for it should be '*a social and community matter.*' While recognising that finances are scarce, it is important to recognise that older people are limited in their choice about what care and support to purchase if few options suitable for their transport and support needs are available. Further research would be needed to explore the costs of day centres and any expenditure-related benefits.

Some implications for policymakers, for practice and also recommendations for further research have arisen from this study. These are set out in 11.5 and 11.6 after the study's strengths and limitations and personal reflections on these, have been considered.

11.3 Study strengths and limitations

I acknowledge certain limitations of this research. Although in-depth, it was a small study. Nevertheless, it has painted a rich picture of a single day at four centres. From this, some generalisability is possible about who attends and what happens at the three centres operating for more than one day, on their other days. Its limitations were compensated for, to a degree, by the diversity of day centre typologies covered and the emergence of common themes across all four centres. The strengths and limitations of this study, the samples, the methodological approach taken, the conduct of the fieldwork and approaches to data analysis are detailed in the following sub-sections.

11.3.1 Scope of the study

Strengths of this study are its focus on generalist day centres, its focus on entire experiences and outcomes of day centres rather than on certain parts of attendance or experiences, and the multiple perspectives it gathered. The study's scope was limited by the exclusion of health professionals' perspectives. Further limitations relate to researcher capacity and project timescales, which led to the participation of only four day centres in one English region and small sample sizes, and to its lack of coverage of another important gap identified in the 2005-2017 literature, namely the finances of day centres.

11.3.2 The samples

While the day centre case studies are varied, they do not reflect all typologies and are small in number. However, this study was principally concerned with improving the understanding of day centres' purpose and role, how they are viewed and their use within a changing policy and practice context by painting a rich and contemporary picture; it did not aim to be representative of all day centres. A risk of bias is inherent in that poor-quality day centres may not have agreed to participate in the study.

The perspectives of NHS commissioners and signposters/referrers are missing due to delays in receiving local authority research governance approvals and changes in the national ethics and governance approvals system. Additionally, the ever-changing environment led to challenges in recruiting day centres, overall lower numbers of attenders and a lower proportion of attenders eligible to participate in the study than expected. Nevertheless, the validity of its findings is enhanced by the diversity of participating centres and the multiplicity of perspectives gathered.

Samples may not have been representative. Attenders were recruited from numbers that were smaller than expected and the group of attenders opting not to participate included people with health or other problems, such as bereavement or family matters, occupying their minds and depleting their energy. Hence, frailer and less cognitively able attenders may be under-represented, although attender participation was high among those eligible. Nevertheless, many non-participant attenders expressed similar views and experiences as participants in conversation during fieldwork. Although the attender sample was relatively mixed, the majority of family carers were middle class.

While managers of day centres collaborated positively in recruitment, gatekeeping behaviour was noticeable among managers in local authorities who appeared to consider frontline social care staff vulnerable (Witham *et al.*, 2015) in some way or perhaps too busy to engage in research.

11.3.3 Methodological approach and data collection

Using a multiple, embedded case study approach has generated a detailed picture of day centres, their users and of the views and perceptions of people involved in them. To counteract criticisms of this methodological approach (see 3.1.1), several measures were taken to maximise the study's rigour. Regular visits habituated day centre participants to my presence, led to a trusting rapport and enabled me to raise anything I had observed or that had previously been mentioned in conversation but that had not yet arisen in interviews. Interview questions underwent scrutiny to minimise the risk of wording bias. Interviews were recorded and transcribed to eliminate interviewer recall bias. A reflective diary was kept. A systematic approach was taken throughout, including the development of a case study database to store data collected. Using specialised software facilitated systematic analysis of interview and validated scale data.

As a cross-sectional study, the findings provide an in-depth snapshot of one day at each centre rather than a longitudinal overview. Selecting the versions of ASCOT that enable the measurement of hypothetical outcomes in the absence of service at a single time point aimed to compensate for this to a degree. A more comprehensive picture of attenders and of attendance numbers over the previous five-year period would have been possible had managers provided aggregate, anonymised demographic and attendance data as requested.

While acknowledging that mixing methods was ambitious, given my novice status, as a descriptive and explanatory study, combining methods yielded data that is potentially more helpful for service providers (Willis *et al.* 2016) and statutory bodies. Qualitative findings provided rich and in-depth insights into service use, factors contributing to outcomes experienced and the reasons participants valued these, while the quantitative measure enabled quantification of impact preferred by funders. With limited resources to collect data in day centres or analyse data in local authorities, confirming that a quantitative tool is quick to administer and analyse, evidencing how it (partly) conveys the essence of day centres' unique contributions to individual quality of life may be valuable. Demonstrating this overlap may be reassuring for day centre managers considering employing ASCOT INT4 and funders with quantitative preferences wishing to undertake evidence-based commissioning. However, combining methods lengthened interviews, which may have deterred participation. Furthermore, presenting integrated outcomes findings within word limits was challenging.

Self-reporting of certain factual data, such as length of attendance at day centres, access route or health conditions, was subject to recall error. However, a request to seek attenders' consent to access personal records held by day centres to verify such data was rejected by the HRA Social Care Research Ethics Committee (SCREC).

11.3.4 Data analysis

Supervisors supported the analysis process to minimise the risk of bias. Both positive and negative findings are reported. Additionally, data collected using validated scales are comparable.

The Study Advisory Group provided feedback on interpretation of data, having been invited to a workshop, together with representatives from each case study site, to consider the development of recommendations concerning policy and practice. This enabled independent appraisal of data interpretations which reinforced the transparency and trustworthiness of the findings.

11.4 Reflections on methodology, fieldwork, ethical concerns and the topic of this thesis

In this section I offer some personal reflections.

11.4.1 Methodological approach

That the proposed methodology of undertaking a period of regular visits to centres appeared partly observational arose at the HRA SCREC meeting at which I explained, to members' satisfaction, that diary notes would inform in-depth descriptions and would not be at the detailed level appropriate for an ethnographic study using observational methodology. In this thesis, I have been careful not to take an observational perspective, which has been challenging. It was tempting to describe attenders' enthusiasm for singing, their engagement in a poetry reading session, lack of enthusiasm for exercise or conversations about unappetising food followed by comments about how lovely it was to have had a hot meal. I have limited myself to brief observations which I considered necessary to supplement particular sections. As well as staying true to the study's aims, I feel this has enabled analysis and interpretation to be non-evaluative.

11.4.2 Fieldwork

Visiting regularly on a set day maximised both recruitment and authenticity of the findings and staying for whole days without leaving for a lunch break appeared to demonstrate my genuine interest. As a researcher, visits provided the opportunity to mingle informally and join in activities (e.g. exercises, craft, card games, lunch) which, I believe, helped participants accept me into their group, trust me and feel comfortable about answering interview questions. Doing this also gave me an insight into non-participant attenders' general feelings about centres. Using focus groups may have increased participation; some non-participating attenders were particularly vocal about their views during usual attendance days and in meetings of attenders. Individual interviews to gather socio-demographic data and administer scales would still have been necessary if using focus groups. From individual conversations during fieldwork, however, I believe that both eligible and non-eligible participants' contributions are likely to have echoed some of participants' data meaning that the richness of the data was not compromised by having a small sample.

Having built relationships and exchanged information about each other's backgrounds, my impression was not that participants gave socially desirable responses in interviews, contrary to Dabelko-Schoeny and King's (2010) intimation. What was said in interviews matched what had already been revealed in conversation or I had witnessed at centres. This was the case both for interviews at centres and at interviewees' homes. Only one attender, with a learning disability, used facial expressions to infer negative answers to one or two questions when seeming loathe to express his thoughts in words.

Many judgements were involved in deciding when to distribute Information Sheets and when to ask attenders directly about participation. My efforts to maintain confidentiality of participation appeared to make attenders at the pilot centre feel singled out and unhappy about this. After this, I became more open about participation conversations while remaining aware of the delicate balance necessary in order not to offend those not meeting inclusion criteria. On a few occasions, I had to decline the offer to be interviewed from enthusiastic attenders not meeting inclusion criteria, doing so by apologising for not being able to interview everyone, as I had a ceiling number, which they accepted graciously. Before directly asking about participation, at all centres, I waited until I felt I had been accepted by the group as a regular – something that occurred at all centres – and ensured that I had had several conversations with those I was inviting to participate. This was a reason for extending each visit period from 12 to 14 weeks. The seating format and day's structure influenced my approach as private conversations, particularly with deaf or hard of hearing attenders, were only possible at certain times. This was often when attenders were moving from one area to another, for example from an activity to lunch. Although distances were not long, poor mobility often meant conversations were long enough to cover everything necessary or arrange a further conversation about participation.

I had not anticipated the impact that an extended visit period would have on me and, in some cases, on others. The emotional labour (Wharton 2009) involved became more apparent towards the end of the data collection period. Maintaining a happy and interested appearance became more demanding as my eagerness for mixing and chatting with attenders waned somewhat when I was tired, despite having an enthusiastic personality. However, this was not counterproductive as I used such times to chat with staff or volunteers instead, or listened to what was going on from a slight distance rather than sitting within the group. Final visits were emotional as I said goodbye to everybody individually as well as thanking the whole group when presenting the centre's certificate of participation and donation. Some attenders, staff and volunteers said they would miss me and asked if they would see me again or if I could stay as staff or volunteer. I was requested to drop in to visit, which I have done within limits. A few attenders implied invitations to

visit them at home by reminding me that I knew where they lived, which I have not done. I was also invited to join one centre for its Christmas lunch which I did. Two centres presented me with a goodbye card, gave me gifts (flowers, chocolates and framed quotations) and seemed genuinely sad that my visits were over. Some staff revealed that they had been worried about me being there making notes but had relaxed after a few weeks when they started to get to know me and saw how I joined in and spoke with everyone. Managers and staff also said how they had appreciated my joining in with organised activities, that I mixed with all attenders, not just those meeting eligibility criteria and the help I offered (e.g. collecting cups, one-to-one support to join in musical bingo or craft, leading charades, storing chairs, holding doors open). Managers, staff and volunteers at all day centres were extremely supportive and enabling throughout which I had not envisaged; there was a risk that staff may have felt as if they were being evaluated. Without their support in reassuring some attenders about the content of my research, I may have recruited fewer participants.

How my extended visits impacted on one specific attender stood out for me. A very private person, staff had advised me she would be unlikely to participate and even more unlikely to have an interview in her home, which is where the interview took place after she agreed to participate straightaway when asked. When saying goodbye on the final day, she took my hands and said how much she had enjoyed our chats and that she would miss me. She said she had not chatted much at the centre before I arrived and now she felt much more conversational. Because she had mentioned to me her dislike of the current trend for hugging and kissing on meeting or saying goodbye, I acknowledged she did not enjoy physical contact so probably would not like a hug from me. She held open both arms, smiled and said that she would love a hug.

11.4.3 Ethical concerns

Although there will always be ethical concerns about carrying out research with vulnerable older people, my experiences suggest that their resilience and keenness to tell their stories may be under-estimated by those granting ethical permissions or acting as gatekeepers. Many older participants welcomed the opportunity for a home visit and to talk about themselves without interruption or time limitations. Some attenders even showed me photographs, their garden and offered never-ending tea. Many carers, once recruited, were enthusiastic to explain how their family member's attendance at a day centre had made a difference to them and to the attender. By being over-protective and focusing on potential negative impact rather than potential positive impact, the ethical approval process can restrict the extent of research. Five examples exemplify this point. First, one attender commented that she had really enjoyed the interview and my visit to her home which reflects the importance attached to offering hospitality (Lewinter 2003); like most attenders, she requested to continue with the second part of the interview directly after the first.

Furthermore, in answering my questions, she had realised how lucky she was. I raised earlier (see 3.6.2) how some participants said that participation was therapeutic. Second, another attender cried when explaining how her reduced mobility made her feel, but was keen to continue with the interview after a short break because she wanted to contribute her experiences to this study. Third, after an interview, a carer said she was proud that this had been the first time she had talked about her family member's situation without crying. Fourth, my regular visits to the centre and ability to sit and chat with attenders, without the time constraints staff had, impacted on the attender mentioned above who felt an element of 'social rehabilitation' had occurred. Finally, one attender requested I report her annoyance at being asked factual questions to which I could have found the answers in her files, had I been permitted access to these.

Access to personal records held by centres was rejected by the ethics committee due to concerns that family carers' details may appear in these and they would not have consented to their access. This rejection also had a broader impact in that some attenders did not reveal health conditions I knew about from staff, such as dementia or incontinence, when asked about these in interviews or did not know how they had been referred or signposted to their centres. This posed a dilemma concerning whether to report attenders' responses or separately sourced facts. I concluded that, since the overarching aims of this study were descriptive and explanatory, and because it has assembled data previously overlooked, its findings offer valuable insights regardless of this shortcoming. Furthermore, some attenders' lack of awareness of such matters (e.g. health, how they accessed centres) is also a finding.

11.4.4 Study redesign?

A retrospective evaluation of this study, with possible changes in its design in mind, confirmed my view that the multiple embedded case study methodological approach used was highly appropriate for the research questions and the setting investigated, as were the day centre identification, data collection and analysis methods. The following changes may enhance the findings if repeating the study. Recruiting a fifth day centre that was completely volunteer-run and not affiliated to a national body would add further depth, potentially broadening the applicability of this study's findings considerably, but doing so would require an extended timescale. Similarly, gaining an NHS perspective on day centres would render the picture more complete; it would also enable further discussion of views on day centres' current place and their potential for the future. Lastly, it is possible that more views on the best and worst aspects of centres and any suggestions for change may have been forthcoming had these been investigated in a focus group.

I have seven observations with respect to the way I undertook the study. First, in applying for ethical approval, challenging successfully the committee's decision to disallow access to day centre

records may have reduced the burden of questioning on attenders and would have meant that factual data was correct. Second, it may have been more time-efficient to seek Research Governance approval through the Association of Directors of Adult Social Services even when the planned number of participating local authorities was on the cusp of the requirement to apply through them (currently four or more). Conversely, I would not have made the connections with local authorities that I did while applying for this directly. Third, I had not anticipated such considerable difficulty in identifying and recruiting carers; reviewing the literature on this topic before designing the study may have informed an alternative and more successful strategy. Fourth, with respect to day centres, requesting to attend a planned staff/volunteer meeting, if there was one, prior to starting fieldwork visits would ensure everyone was fully briefed, that any concerns were allayed and would have given the opportunity for questions to which all may hear the answer. Fifth, to compress the data collection period, I would overlap fieldwork visit periods by three weeks instead of undertaking these consecutively, since the first few weeks at a centre were a quiet, 'settling in' period. Sixth, it was not until I was relatively far into data analysis that I recognised a gap in the questions for attenders; I had not asked a direct question about what the outcomes attenders experienced meant for the overall, bigger picture of their lives. Finally, my plan for outcomes data presentation at design stage could have been more detailed.

11.4.5 The topic and my conclusions

I have noticed that day centres for older people evoke similar reactions to Marmite in that opinions are clearly divided and often extreme. Unlike Marmite, it seems that these judgements are sometimes made without experience or knowledge. Of the people with whom I have spoken about this research, enthusiasts blew the trumpet for day centres, eagerly saying that outcomes for attenders would relate to social contact and meals, while others said that day centres were old-fashioned and that nobody – and certainly not *them* – wants to attend such places any more. I have found, however, that attenders experience additional outcomes beyond social contact and meals, providing evidence that day centres still have a role, are relevant to policy and that there is potential for development of their systemic contribution to social care and health. I had a proud moment at the final Study Advisory Group meeting at which I presented these findings. A member – a carer with experience of day centres as a worker, manager and senior manager – declared that, unlike much of the research he had read, he felt I had succeeded in depicting the essence of day centres as a service and their value. Meanwhile, another member was involved in reducing their commissioning. Doctoral studies have compelled me to set aside my own positive personal feelings about day centres so that I do not make overly-positive interpretation of the data. My methods have represented what participants said, but I appreciate that the views of older people who reject day centre attendance would be helpful in exploring whether other options produce

similar gains in wellbeing. The research design was very helpful in setting out a range of methods that might be taken further to other groups.

11.5 Implications for policymakers and practice

The implications for policymakers, for local authority practice and for day centre providers arising from this research are set out below, having been endorsed by the Study Advisory Group and case study site representatives with whom the findings were shared.

There is a need for policymakers to look beyond the obvious costs of day centres when commissioning or reviewing provision; day centres offer added value beyond social inclusion, care, stimulating activities and respite. Undertaking commissioning without a full understanding of day centres' outcomes contravenes the principles of evidence-based commissioning by relying on individual knowledge which may be based on assumptions or experience of different client groups. Likewise, when reviewing service provision, proposals based on responses to consultations will generate evidence-based commissioning decisions. In thinking about change, innovation is more than devising new models; it is about changing ways of thinking and working to maximise potential, reach and efficiency. However, financial pressures are giving rise to reductions of support for older people and any potential cost savings linked with day centre use have not been analysed. More joined-up commissioning will go some way towards optimising services.

Funders endeavouring to carry out evidence-based commissioning will need to refine their views on what constitutes good evidence and will have to be informed by costings of capital and revenue. Methods classed as 'gold standard' (e.g. randomised controlled trials) are less appropriate for social care interventions than they are for clinical ones in which input and the cost-effectiveness of outcomes can be clearly identified. Unless there is a change in mindset, whereby quantitative evidence is no longer privileged over qualitative, the perceived evidence gap concerning the impact of social care will persist to the detriment of preventive services, such as day centres. This study has not only demonstrated the utility of a straightforward validated tool in demonstrating service outcomes, it has also shown the complementarity of qualitative and quantitative methods in a common social care service, the nature of which is heterogeneous and has demonstrated that qualitative research may be robustly designed to produce valuable evidence. However, funders will also need to appreciate the substantial time required to fulfil the ethical and governance controls required and to collect and analyse qualitative data.

Social care professionals who commission or make referrals to day centres and those taking management decisions about such referrals may wish to undertake day centre visits to improve their understanding of what day centres offer to their users as whole services and the relevance of

their outcomes to policy. They may also wish to familiarise themselves with the evidence concerning day centres. Local authority referrers may wish to consider day centre attendance as part of a whole care and support package and, following the principles of personal budget holding, ensure that older people know how attendance is paid for.

Day centres may wish to introduce regular monitoring using validated tools which will produce valuable evidence of service impact and to actively seek opportunities to use such data. Finally, since data on cost per place is essential for establishing 'value' in the context of impact, there is a need for providers to produce cost data. As 'businesses' or not-for-profit operations, marketing is becoming critical for day centres. To increase awareness of centres and to improve connections with their communities, they may wish to consider, for example, ensuring their decoration reflects the enjoyment their attenders gain (e.g. craft displays), operating an annual open day or publishing 'good news' articles in local papers particularly when news is scant, such as in summer.

11.6 Recommendations for further research

Several areas which merit further investigation have arisen from this study. The following recommendations for research were endorsed by the Study Advisory Group and case study site representatives with whom the findings were shared.

1. NHS professionals' views on day centres

Although the design of this study included gathering the views of NHS professionals, this was not achieved. The findings, however, have offered some insights into centres' current relationships with the NHS, together with local authority and centre manager views on their potential future development, much of which would require partnership working with the NHS. A further study could usefully explore NHS professionals' and commissioners' awareness of and views on generalist day centres, their purpose and potential.

2. Attender and volunteer quality of life, wellbeing and loneliness

Impact is an important issue for future research, particularly since evidence-based commissioning is encouraged, and this study has indicated day centres' relevance to the current policy theme of promoting wellbeing. In the qualitative part of this study, attender and volunteer participants reported improved wellbeing resulting from day centre involvement. Quantitative data gathered pertained to attenders' quality of life at the time of fieldwork and in a hypothetical situation in which a day centre was no longer attended and nothing took its place. While this indicated individual quality of life gain resulting from day centre attendance, thus isolating its contribution to quality of life, it did not measure individual changes in levels of wellbeing. In view of the perceived greater acceptability of quantitative data and because this study found the use of a

validated tool to measure wellbeing unproblematic, a 'shortitudinal' study using validated tools with new attenders and volunteers may usefully be undertaken. Tools may include the SWEMWBS and/or the eight-question version of ASCOT. Consideration may be given to the use of an additional validated tool to measure loneliness. Contextual data gathered will also need to be gathered and updated.

3. Day centres' costs, pricing and charging

There is abundant room for further progress in exploring the finances of day centres. Several questions remain unanswered at present, for example what is the cost per hour/day/place and of transport. Further research in this field would be of great help in making full use of ASCOT as a cost-utility tool. It would also improve the understanding of the challenges of providing a service within the current social care market in which funding and clientele levels are uncertain. A study on this topic is, therefore, recommended.

4. The culture within a day centre

This study has found that process outcomes of day centres are better for attenders than carers, that staff experience job satisfaction, and staff retention is above average for older people's social care services. Since process outcomes are one indicator of service quality, research is needed to better understand what creates the culture within a centre and to explore the links between culture and outcomes. This may address, for example, what a manager's role involves, what culture prevails and the role it plays, what role the building/environment plays and whether this transcends a manager's influence. The findings may inform the development of a model of day centre culture, as there is for care homes (see www.myhomelife.org.uk).

11.7 To conclude

This thesis has provided evidence that the generalist day centres for older people in this study played an important role for the individuals involved with them by delivering valued outcomes that are highly relevant to social care and health policy themes, and that there is potential to develop their systemic role.

Centres' role, for their attenders, within the mosaic of informal and formal care and support provision, was described as supplementing or replacing inadequate informal care, support, social networks or other opportunities for vulnerable people who were housebound but not necessarily frail. Thus, staff and volunteers may become the 'chief non-familial carers' for some attenders, and centres are attended after it has become impractical to use universally accessible community facilities (e.g. 'drop-in' community centres, leisure centres) due to the onset of transport and other support needs. Centres' focus was on the higher order outcomes associated with wellbeing of quality of life. For their volunteers, they were a source of active ageing activity. For their staff, they

offered a source of job satisfaction. For those who signposted or referred to them, they were a support tool available for use with clients. Some consideration may need to be given to providing suitable alternative opportunities for the increasing proportions of attenders with dementia who, while not normally perceived as disruptive, did negatively affect other attenders' experiences to a degree.

Turbulence and crises, while sometimes being obstructive, may also be useful for generating new approaches and ways of thinking about how to address situations. The transitional period, detailed in Chapter 2, of public funding pressures in which numbers of day centres have reduced and their viability has been compromised by reductions in and the uncertainties of short-term funding, together with the demographic context outlined above have given rise to an opportunity for development. Lloyd *et al.* observed that having a '*reputation as an 'old fashioned' and institutionalised form of service (...) neglects the potential of day services to adapt and respond to contemporary expectations*' (Lloyd *et al.* 2014: 34). Although the first part was not borne out by the findings of this study, such views may perpetuate among other decision-makers working in health and social care. Yet continuing to close day centres, perhaps as a result of subscribing to this view, may be a false economy since attenders with a similar profile to this study's participants, and carers, may need a care and support package if they no longer had their centre. The activist age sector may wish to campaign for the optimising of day centre services to maximise the impact of the health and social care system. Any perceptions of day centres as old-fashioned could be challenged by the age activist or campaigning sector. The current financial constraints could be used as leverage to explore, at strategic organisational level, how partnership working with other parts of social care and the NHS may be improved, and to explore how to recover attendance levels. Doing so may contribute to expanding day centres' 'offer' to the system, thereby maximising the added value this study found.

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Appendices

Appendix 1 Ethical approval (HRA SCREC)



Social Care REC

Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Telephone: 0207 972 2568

24 June 2015

Mrs Katharine Orellana
Social Care Workforce Research Unit
King's College London
Strand
London
WC2R 2LS

Dear Mrs Orellana

Study title: The future of day centres for older people - in search of the evidence on their role, outcomes and commissioning

REC reference: 15/IEC08/0033

IRAS project ID: 178379

Thank you for your letter of 18 June 2015, which provided a very comprehensive response to our letter dated 12 May 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 12 May 2015.

Thank you for clarifying our point 2.3 – '*Add information about which carers are going to be interviewed*'. The approach you have taken to address this point is very clear and appropriate.

Documents received

The documents received were as follows:

Document	Version	Date
Covering letter on headed paper		18 June 2015
Letters of invitation to participant [Day Centres]	2	28 May 2015
Participant consent form [Attendees]	2	28 May 2015
Participant information sheet (PIS) [Carers]	2	28 May 2015
Participant information sheet (PIS) [Attendees]	2	28 May 2015
Participant information sheet (PIS) [Managers/Trustees/Owners]	2	28 May 2015

Participant information sheet (PIS) [Signposters/referrers]	2	28 May 2015
Participant information sheet (PIS) [Commissioners]	2	28 May 2015
Participant information sheet (PIS) [Frontline Staff]	2	28 May 2015
Participant information sheet (PIS) [Frontline Volunteers]	2	28 May 2015

Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [SCREC ethics application submission cover letter]	1	17 April 2015
Covering letter on headed paper		18 June 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2014-15 KCL's Professional Indemnity Policy Schedule]	1	01 August 2014
Interview schedules or topic guides for participants [Interview schedule - attenders]	1	17 April 2015
Interview schedules or topic guides for participants [Interview schedule - carers]	1	17 April 2015
Interview schedules or topic guides for participants [Interview schedule - frontline volunteers]	1	17 April 2015
Interview schedules or topic guides for participants [Interview schedule - frontline staff]	1	17 April 2015
Interview schedules or topic guides for participants [Interview schedule - managers-trustees-owners]	1	17 April 2015
Interview schedules or topic guides for participants [Interview schedule - commissioners]	1	17 April 2015
Interview schedules or topic guides for participants [Interview schedule - referrers/signposters]	1	17 April 2015
IRAS Checklist XML [Checklist_17042015]		17 April 2015
Letter from funder [Dunhill award letter 18-6-14]	1	17 April 2015
Letter from sponsor [KCL Confirmation of study letter 18-9-14]	1	17 April 2015
Letters of invitation to participant [Invitation letter - health & social care professionals]	1	17 April 2015
Letters of invitation to participant [Day Centres]	2	28 May 2015
Other [CV - academic supervisor 1 Jill Manthorpe]	1	10 April 2015
Other [CV - academic supervisor 2 Anthea Tinker]	1	10 April 2015
Other [Showcards - interview - attenders (part 3)]	1	17 April 2015

Other [Showcards - interview - attenders (part 5)]	1	17 April 2015
Other [Showcards - interview - carers (part 4)]	1	17 April 2015
Other [Showcards - interview - carers (part 6)]	1	17 April 2015
Other [Showcards - interview - managers-trustees-owners]	1	17 April 2015
Other [Showcards - validated scale ASCOT INT4]	1	17 April 2015
Other [Showcards - validated scale ASCOT INT4 carers]	1	17 April 2015
Other [Showcards - validated scale EFS]	1	17 April 2015
Other [Showcards - validated scale PANT]	1	17 April 2015
Other [Showcards - validated scale SWEMWB]	1	17 April 2015
Other [List of useful organisations]	1	17 April 2015
Other [Map of a usual week (A3)]	1	17 April 2015
Participant consent form [Consent form - carers]	1	17 April 2015
Participant consent form [Consent form - frontline volunteers]	1	17 April 2015
Participant consent form [Consent form - frontline staff]	1	17 April 2015
Participant consent form [Consent form - managers-trustees-owners]	1	17 April 2015
Participant consent form [Consent form -commissioners]	1	17 April 2015
Participant consent form [Consent form - referrers/signposters]	1	17 April 2015
Participant consent form [Attenders]	2	28 May 2015
Participant information sheet (PIS) [Carers]	2	28 May 2015
Participant information sheet (PIS) [Attenders]	2	28 May 2015
Participant information sheet (PIS) [Managers/Trustees/Owners]	2	28 May 2015
Participant information sheet (PIS) [Signposters/referrers]	2	28 May 2015
Participant information sheet (PIS) [Commissioners]	2	28 May 2015
Participant information sheet (PIS) [Frontline Staff]	2	28 May 2015
Participant information sheet (PIS) [Frontline Volunteers]	2	28 May 2015
REC Application Form [SC_Form_17042015]		17 April 2015
Research protocol or project proposal [Research proposal]	1	13 October 2014
Summary CV for Chief Investigator (CI) [CV - Katharine Orellana]	1	17 April 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Flow chart of research]	1	17 April 2015

Validated questionnaire [Validated scale - ASCOT IN4]		
Validated questionnaire [Validated scale - ASCOT INT4 carers (final draft)]		
Validated questionnaire [Validated scale - Edmonton Frail Scale]		
Validated questionnaire [Validated scale - Practitioners Asst of Network Type]	1	17 April 2015
Validated questionnaire [Validated scale - Short Warwick Edinburgh Mental Wellbeing]	1	17 April 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/IEC08/0033	Please quote this number on all correspondence
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Yours sincerely




Barbara Cuddon REC Manager

E-mail: nrescommittee.social-care@nhs.net

Copy to: *Professor Jill Manthorpe, King's College London*
Ms Tumi Kaminskis, South West Cluster Office, 16th Floor, Guy's Tower

Appendix 2 Scan of Enhanced Disclosure and Barring Service Check Certificate

Enhanced Certificate Page 1 of 2		 Disclosure & Barring Service
		Certificate Number 001485970238
		Date of Issue: 11 MAY 2015
Applicant Personal Details		Employment Details
Surname:	ORELLANA	Position applied for: ADULT WORKFORCE PHD RESEARCHER
Forename(s):	KATHARINE ELIZABETH	Name of Employer: KINGS COLLEGE LONDON
Other Names:	████████████████████	
Date of Birth:	██████████	Countersignatory Details
Place of Birth:	██████████	Registered Person/Body: KING'S COLLEGE LONDON
Gender:	FEMALE	Countersignatory: LOIS THORLEY
Police Records of Convictions, Cautions, Reprimands and Warnings		
NONE RECORDED		
Information from the list held under Section 142 of the Education Act 2002		
NONE RECORDED		
DBS Children's Barred List information		
NONE RECORDED		
DBS Adults' Barred List information		
NONE RECORDED		
Other relevant information disclosed at the Chief Police Officer(s) discretion		
NONE RECORDED		
Enhanced Certificate This document is an Enhanced Criminal Record Certificate within the meaning of sections 113B and 116 of the Police Act 1997.		
THIS CERTIFICATE IS NOT EVIDENCE OF IDENTITY		Continued on page 2

Appendix 3 Validated scales

3.1 Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)

The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

**Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of
each over the last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

"Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS)
© NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved."

3.2 Edmonton Frail Scale (EFS)

The Edmonton Frail Scale

Frailty domain	Item	0 Point	1 Point	2 Points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1–2	≥2
	In general, how would you describe your health?	Excellent/Very good/Good	Fair	Poor
Functional independence	With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)	0–1	2–4	5–8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then when I say 'GO', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down	0–10 seconds	11–20 seconds	One of >20 seconds, patient unwilling or requires assistance
Total	Final score is the sum of column totals			/17

SCORE:

Column B	_____ x 1 pt = _____
Column C	_____ x 2 pt = _____
Total Score:	_____ /17

3.3 Practitioner Assessment of Network Type (PANT)

Instructions

1. Ask all questions and circle code
2. Circle same code across all boxes on same line
3. Count circled codes for each network column and enter number at bottom of column
4. Highest number on bottom line will be in column of respondent's network type

Question	Response categories	Code	Family dependent	Locally integrated	Local self-contained	Wider community focused	Private
1. How far away, in distance does your nearest child or other relative live? <i>Do not include spouse</i>	No relatives	A					
	Same house/within 1 mile	B	B				
	1–5 miles	C		C			
	6–15 miles	D		D	D		
	16–50 miles	E			E	E	E
	50+ miles	F				F	F
2. If you have any children, where does your nearest child live?	No relatives	A			A		A
	Same house/within 1 mile	B	B	B			
	1–5 miles	C	C	C			
	6–15 miles	D		D	D		
	16–50 miles	E			E		
	50+ miles	F				F	F
3. If you have any living sisters or brothers, where does your nearest sister or brother live?	No sisters or brothers	A				A	A
	Same house/within 1 mile	B	B	B			
	1–5 miles	C	C	C	C		
	6–15 miles	D		D	D		
	16–50 miles	E			E		
	50+ miles	F				F	F
4. How often do you see any of your children or other relatives to speak to?	Never/no relative	A					A
	Daily	B	B	B			
	2–3 times a week	C	C	C			
	At least weekly	D			D		
	At least monthly	E			E	E	
	Less often	F				F	F
5. If you have friends in this community/neighbourhood, how often do you have a chat or do something with one of your friends?	Never/no friends	A					A
	Daily	B		B		B	
	2–3 times a week	C		C		C	
	At least weekly	D		D		D	
	At least monthly	E	E		E		
	Less often	F	F		F		F
6. How often do you see any of your neighbours to have a chat with or do something with?	No contact with neighbours	A	A				A
	Daily	B		B			
	2–3 times a week	C		C			
	At least weekly	D		D	D	D	
	At least monthly	E	E		E	E	
	Less often	F	F				F
7. Do you attend any religious meetings?	Yes, regularly (at least once a month)	A		A		A	
	Yes, occasionally	B	B		B	B	
	No	C			C		C
8. Do you attend meetings of any community/neighbourhood or social groups, such as old people's clubs, lectures or anything like that?	Yes, regularly (at least once a month)	A		A		A	
	Yes, occasionally	B	B		B		
	No	C	C		C		C
Network type (highest number)							

Information received from (code as appropriate): 1. All from client/patient; 2. Some or all from proxy.

This form should only be used in conjunction with the appropriate training package devised by Professor G. Clare Wenger, Centre for Social Policy Research and Development, Institute for Medical and Social Care Research, University of Wales, Bangor, LL57 2PX.

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3.4 Adult Social Care Outcomes Toolkit (ASCOT) INT4

CONTENT REDACTED

CONTENT REDACTED

Control over daily life

1. Which of the following statements best describes how much control you have over your daily life?

Interviewer prompt: By 'control over daily life' we mean having the choice to do things or have things done for you as you like and when you want.

If needed, please prompt: When answering the question, think about your situation at the moment.

Please tick (☑) one box

I have as much control over my daily life as I want

☐

I have adequate control over my daily life

☐

I have some control over my daily life, but not enough

☐

I have no control over my daily life

☐

2. Do the support and services that you get from <<EXAMPLE>> affect how much control you have over your daily life?

Interviewer prompt: By 'support and services' we mean, for example, <<EXAMPLE>> [interviewer should either (a) Insert the name of the specific service that is being investigated (for example, home care, personal budget); or (b) (If asking about the service user's full social care package) give some examples of the support and services that the service user is receiving]. Please do not include help from health professionals, such as GPs and nurses, or from friends and family.

Please tick (☑) one box

Yes

☐

No

☐

Don't know

☐

If 2 = yes or don't know, then go to question 3

If 2 = no, then go to question 4

3. Imagine that you didn't have the support and services from <<EXAMPLE>> that you do now and no other help stepped in. In that situation, which of the following would best describe the amount of control you would have over your daily life?

Interviewer note: It is important that respondents do not base their answers on the assumption that any other help steps in; please emphasise this to interviewees.

Reassure if necessary: Please be assured that this is purely imaginary and does not affect the services you receive in any way.

Please tick (☑) one box

I would have as much control over my daily life as I want

☐

I would have adequate control over my daily life

☐

I would have some control over my daily life, but not enough

☐

I would have no control over my daily life

☐

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

22. Which of these statements best describes how having help to do things makes you think and feel about yourself?

Please tick (☑) one box

Having help makes me think and feel better about myself	<input type="checkbox"/>
Having help does not affect the way I think or feel about myself	<input type="checkbox"/>
Having help sometimes undermines the way I think and feel about myself	<input type="checkbox"/>
Having help completely undermines the way I think and feel about myself	<input type="checkbox"/>

23. Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?

Please tick (☑) one box

The way I'm helped and treated makes me think and feel better about myself	<input type="checkbox"/>
The way I'm helped and treated does not affect the way I think or feel about myself	<input type="checkbox"/>
The way I'm helped and treated sometimes undermines the way I think and feel about myself	<input type="checkbox"/>
The way I'm helped and treated completely undermines the way I think and feel about myself	<input type="checkbox"/>

(c) PSSRU at the University of Kent

This interview schedule has been developed by members of the Personal Social Services Research Unit (PSSRU) at the University of Kent at Canterbury, United Kingdom (UK). The work has been substantially funded by the Quality and Outcomes of Person-Centred Care Research Unit (QORU) under the Policy Research Programme in the UK Department of Health. The views expressed are not necessarily those of the Department. The University of Kent is the sole owner of the copyright in these materials. The University of Kent authorises non-commercial use of this interview schedule on the condition that anyone who uses it contacts the ASCOT team (ascot@kent.ac.uk) to discuss this use and enable the PSSRU at University of Kent to track authorised non-commercial use. The University of Kent does not authorise commercial use of this interview schedule. Anyone wishing to obtain a licence for commercial use of any of the ASCOT materials should contact the ASCOT team, who will put them in touch with Kent Innovation & Enterprise.

3.5 Adult Social Care Outcomes Toolkit (ASCOT) INT4 Carers

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

Occupation

1. Which of the following statements best describes how you spend your time?

Interviewer prompt: When you are thinking about how you spend your time, please include anything you value or enjoy, including leisure activities, formal employment, voluntary or unpaid work, and caring for others.

If needed, please prompt: When answering the question, think about your situation at the moment.

Please tick (☑) one box

I'm able to spend my time as I want, doing things I value or enjoy ☐

I'm able to do enough of the things I value or enjoy with my time ☐

I do some of the things I value or enjoy with my time, but not enough ☐

I don't do anything I value or enjoy with my time ☐

2. Do the support and services that you and [cared-for person's name] get from <<EXAMPLE>> affect how you spend your time?

Interviewer prompt: By 'support and services' we mean, for example, <<EXAMPLE>>

[interviewer should either (a) Insert the name of the specific service that is being investigated (for example, home care, personal budget, carer support group); or (b) (If asking about the full social care package) give some examples of the support and services being received]. Please do not include help from health professionals, such as GPs and nurses, or from friends and family.

Please tick (☑) one box

Yes ☐

No ☐

Don't know ☐

If 2 = yes or don't know, then go to question 3

If 2 = no, then go to question 4

3. Imagine that you and [cared-for person's name] didn't have the support and services from <<EXAMPLE>> that you do now and no other help stepped in. In that situation, which of the following would best describe how you would spend your time?

Interviewer note: It is important that respondents do not base their answers on the assumption that any other help steps in; please emphasise this to interviewees.

Reassure if necessary: Please be assured that this is purely imaginary and does not affect the services you receive in any way.

Please tick (☑) one box

I would be able to spend my time as I want, doing things I value or enjoy ☐

I would be able to do enough of the things I value or enjoy with my time ☐

I would do some of the things I value or enjoy with my time, but not enough ☐

I wouldn't do anything I value or enjoy with my time ☐

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

CONTENT REDACTED

Feeling supported and encouraged

19. Thinking about feeling supported and encouraged in your caring role, which of the following statements best describes your present situation?

Interviewer prompt: If needed, please prompt: *This question is asking about **feeling** supported and encouraged, rather than how you are supported and encouraged by particular people or organisations.*

If needed, please prompt: *When answering the question, think about your situation at the moment.*

Please tick (☑) one box

- | | |
|--|--------------------------|
| I feel I have the encouragement and support I want | <input type="checkbox"/> |
| I feel I have adequate encouragement and support | <input type="checkbox"/> |
| I feel I have some encouragement and support, but not enough | <input type="checkbox"/> |
| I feel I have no encouragement and support | <input type="checkbox"/> |

20. Do the support and services that you and [cared-for person's name] get from <<EXAMPLE>> affect how supported and encouraged you feel in your caring role?

Interviewer prompt: By 'support and services' we mean, for example, <<EXAMPLE>>

[interviewer should either (a) Insert the name of the specific service that is being investigated (for example, home care, personal budget, carer support group; or (b) (If asking about the full social care package) give some examples of the support and services being received]. Please do not include help from health professionals, such as GPs and nurses, or from friends and family.

Please tick (☑) one box

- | | |
|------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Don't know | <input type="checkbox"/> |

If 20 = yes or don't know, then go to question 21

If 20 = no, then end

21. Imagine that you and [cared-for person's name] didn't have the support and services from <<EXAMPLE>> that you do now, and no other help stepped in. In that situation, which of the following would best describe how you would feel?

Interviewer note: It is important that respondents do not base their answers on the assumption that any other help steps in; please emphasise this to interviewees.

Reassure if necessary: *Please be assured that this is purely imaginary and does not affect the services you receive in any way.*

Please tick (☑) one box

- | | |
|--|--------------------------|
| I would feel I have the encouragement and support I want | <input type="checkbox"/> |
| I would feel I have adequate encouragement and support | <input type="checkbox"/> |
| I would feel I would have some encouragement and support, but not enough | <input type="checkbox"/> |
| I would feel that I have no encouragement and support | <input type="checkbox"/> |

(c) PSSRU at the University of Kent

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PANT tool, question 4

<p>4. How often do you see any of your children or other relatives to speak to?</p> <p>A. Never/no relative</p> <p>B. Daily</p> <p>C. 2–3 times a week</p> <p>D. At least weekly</p> <p>E. At least monthly</p> <p>F. Less often</p>	<p>Day Centres for Older People v1</p> <p>Show cards – PANT (day centre attenders)</p> <p>version 1 17.4.15</p>
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Appendix 5 Letters of invitation to participate

5.1 Day centres

ADDRESS

Date

Dear xxx,

Invitation to participate in research about day centres for older people

I am a PhD student at King's College London researching day centres for older people. My study is being funded by Dunhill Medical Trust and is entitled 'The future of day centres for older people: in search of the evidence on their role, outcomes and commissioning'. This letter is to invite you to participate in my research.

My research is an exploration of day centres. It aims to improve the understanding of them within a changing policy and funding environment. I will be investigating their role and purpose, who benefits from them, and how, and how they are perceived. You may know that there is some evidence about the impact of day centres, however day centres are under-researched as whole services.

My study will involve recruiting a small number of day centres as research sites. In each site I would like to interview some day centre attenders, carers of attenders, staff/volunteers (including the manager) and a small number of people from local health and social care who commission and signpost or refer to the day centre. From the manager, I will need to find out about the day centre itself, any plans for the future and what type of service user information is held and how it is used. I will not require access to personal data but rather pro-forma forms, policies about data, details of monitoring tools used, anonymous trends over time and ages of people attending the day centre, for example. From the other interviewees, I will find out about frailty levels and social networks (day centre users only), wellbeing and the outcomes they experience from their involvement with the centre.

My research plans have been approved by the Social Care Research Ethics Committee (ref 15/IEC08/0033) and I am now able to invite day centres to participate, hence this letter. I do hope that you might be interested and I would very happy to visit you to discuss this more fully.

I look forward to hearing from you (contact details below) and to visiting you to discuss this further.

Yours sincerely,

Katharine Orellana

Research Training Fellow (MPhil/PhD student)

Social Care Workforce Research Unit, The Policy Institute at King's
Institute of Gerontology, Dept of Social Science, Health & Medicine
Faculty for Social Science and Public Policy
[TEL] [EMAIL]

5.2 Local authority employees

DATE

Dear ...,

Invitation to participate in research about day centres for older people

I am a PhD student at King's College London researching day centres for older people. My study is being funded by Dunhill Medical Trust and is entitled 'The future of day centres for older people: in search of the evidence on their role, outcomes and commissioning'. A day centre in your area has agreed to be involved in this research, and this letter is to invite you to participate **as health and/or social care employees who commission services or refer/signpost to day centres**.

My research is an exploration of day centres. It aims to improve the understanding of them within a changing policy and funding environment. I will be investigating their role and purpose, who benefits from them, and how, and how they are perceived. As you are probably aware, there is some evidence about the impact of day centres, however they remain under-researched as whole services.

My study will involve recruiting a small number of day centres as research sites. As well as interviewing day centre attenders, their carers, staff and volunteers, I would like to interview a small number of people from local health and social care who commission services and may signpost or refer to day centres. This is to gain a variety of perspectives to enhance the evidence.

My research plans have been approved by the Social Care Research Ethics Committee (ref 15/IEC08/0033), a day centre local to you has agreed to be involved and I am now keen on identifying people working in health and social care who may like to participate, hence this letter. I do hope that you might be interested, or may be able to nominate potential participants. I would very happy to visit you to discuss this more fully. You can read about what your involvement would mean in the enclosed Information Sheet for commissioners and the Information Sheet for professionals who may signpost/refer to day centres [**SELECT AS APPROPRIATE**].

I look forward to hearing from you (contact details below) and to speaking to you about this further.

Yours sincerely,

Katharine Orellana, Research Training Fellow (MPhil/PhD student)

Social Care Workforce Research Unit, The Policy Institute at King's and the Institute of Gerontology,
Dept of Social Science, Health & Medicine, Faculty for Social Science and Public Policy

[TEL NO.]

[EMAIL]

Enclosures: Information Sheet, Consent Form

Appendix 6 Participant information sheets

6.1 Older attenders of day centres

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The study aims to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects.

My name is Katharine Orellana. I am a student at King's College London and this research is for my PhD study.

Why have I been approached?

[NAME OF DAY CENTRE] has agreed to be involved in this research. You are being invited to consider taking part because you attend [NAME OF DAY CENTRE]. Up to 10 people who attend [NAME OF DAY CENTRE] may take part in the study. I will also be interviewing some carers of people who attend and some staff and volunteers here and in other day centres.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. It is important for you to understand that this research is not linked in any way with either service provision of any kind or the future of [NAME OF DAY CENTRE]. The decision to take part or not will not affect any care or support services you receive.

If you are interested, I will explain the study and go through this Information Sheet with you. You can ask if anything is unclear. If you agree to take part, I will ask you to sign a Consent Form and we can arrange the interviews. I would like to talk with you in two interviews which can be carried out a convenient time and place for you, and on a different day if you prefer. You may bring a relative, friend or carer with you to support you in the interviews if you would like to. If you do, it will be up to you to arrange this.

The first interview will last about 1½ -2 hours, and the second 20-30 minutes. With your permission, I would like to record part of the first interview. I will ask what 'a usual week' looks like for you, how you came to be attending the day centre, your experiences of and views on it, what you get out of going there and some questions about yourself. There will also be some questions from measures that assess wellbeing, general health, social support and quality of life. The service you receive from [NAME OF DAY CENTRE] will not be affected by what you say. If you have a carer who also chooses to participate in this research, I will not be making any links between what you tell me and what they say.

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you decide not to take part or decide to withdraw from the study, this will not affect any care or services you receive in any way. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me. What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or area. Please understand, however, that if you tell me something that indicates that you or someone else is at risk of serious harm, then I will be obliged to take appropriate action. This would be discussed with you before telling anyone else.

What are the benefits and risks of taking part?

You may not benefit personally from taking part in the research, but your participation will help to increase what is known about day centres and the people who attend them. To thank you for taking part, you will receive a Certificate of Participation, and you may enjoy an event, or similar social activity, organised by the day centre with a donation that will be given to express my gratitude. A summary of the research findings will be made available to you.

If you feel upset or tired during an interview, we can stop for a break and turn off the voice recorder, end the interview and continue at another time, or you may choose to withdraw from the study. You will also be offered a list of useful organisations.

I have been through checks for your safety.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a professional, who will have signed a confidentiality agreement. I will examine all the information collected for the study and produce articles, presentations and reports aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and my funder. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion (approved) by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on [EMAIL] [TEL] or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS or speak to me on [AGREED DAY].

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my main supervisor Professor Jill Manthorpe:

[EMAIL] [TEL]

Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

6.2 Carers

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The study aims to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects. My name is Katharine Orellana. I am a student at King's College London and this research is for my PhD study.

Why have I been approached?

[NAME OF DAY CENTRE] has agreed to be involved in this research. If you are a carer of someone who attends [NAME OF DAY CENTRE] on [AGREED DAY], you are invited to consider taking part. Up to 5 carers may take part in the study. It does not matter whether or not the person you care for takes part. I will also be interviewing some people who attend and some staff and volunteers here and in other day centres.

By 'carer', I mean a person who provides unpaid care, or support, for a family member or friend who cannot cope without this support due to their illness, disability or a mental health problem. If you are unsure whether or not you are a carer, we can discuss this.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. It is important for you to understand that this research is not linked in any way with either service provision of any kind or the future of [NAME OF DAY CENTRE]. The decision to take part or not will not affect any care or support services you or the person you support receive.

If you are interested, I will explain the study and go through this Information Sheet with you. You can ask if anything is unclear. If you agree to take part, I will ask you sign a Consent Form and we can arrange an interview. This can be carried out a convenient time and place for you and it would last about an hour and 25 minutes. With your permission, I would like to record part of the interview in which I will ask you about your relationship with the day centre, what you get out of the person you care for attending it, what you think they get out of it and some questions about you. I will also ask questions from measures that assess wellbeing and quality of life. The service you and the person you support receive from [NAME OF DAY CENTRE] will not be affected by what you say. I will not be making any links between what you tell me and what the person you support says.

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you decide not to take part or decide to withdraw from the study, this will not affect any care or services you receive, or those of the person you are supporting, in any way. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me in a way that can identify you or the person you are supporting.

What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or area. Please understand, however, that if you tell me something that indicates that you or someone else is at risk of serious harm, then I will be obliged to take appropriate action. This would be discussed with you before telling anyone else.

What are the benefits and risks of taking part?

You may not benefit personally from taking part in the research, but your participation will help to increase what is known about day centres and carers of the people who attend them. To thank you for taking part, you will receive a Certificate of Participation, and the day centre will organise an event, or similar social activity, with a donation I will give to express my gratitude. A summary of the research findings will be made available to you.

You may find it upsetting to talk about why the person you are supporting goes to the day centre or your wellbeing. If you feel upset or tired during an interview, we can stop for a break and turn off the voice recorder, end the interview and continue at another time, or you may choose to withdraw from the study. You will also be offered a list of useful organisations.

I have been through checks for your safety.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a professional, who will have signed a confidentiality agreement. I will examine all the information collected for the study and produce articles, presentations and reports aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and my funder. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion (approved) by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on [EMAIL] [TEL] or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS or speak to me on [AGREED DAY].

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my main supervisor Professor Jill Manthorpe on:

[EMAIL] [TEL] Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

6.3 Day centre volunteers

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people in your organisation. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The study aims to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects,

My name is Katharine Orellana. I am a student at King's College London and this research is for my PhD study.

Why have I been approached?

[NAME OF DAY CENTRE] has agreed to be involved in this research. You are being invited to consider taking part because you are one of its frontline volunteers. Up to 6 volunteers and staff may take part in the study. I will also be interviewing volunteers, staff, older people and carers here and in other day centres.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. It is important for you to understand that this research is not linked in any way with the service provided by [NAME OF DAY CENTRE] or your volunteering activity.

If you are interested, I will explain the study and go through this Information Sheet with you. You can ask if anything is unclear. If you agree to take part, I will ask you sign a Consent Form. An interview will then be arranged. This can be carried out a convenient time and place for you and will last about 50 minutes. You may bring a relative/friend with you to support you in the interview if you wish, or speak to a staff member about being present. It will be up to you to arrange this. With your permission, I would like to record the interview, in which I would ask you about you, your involvement with the day centre, anything you get out of volunteering there and what you think people get out of attending.

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you decide not to take part or decide to withdraw from the study, this will not affect your volunteering activity in any way. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me. What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or area. Please understand, however, that if you tell me something that indicates that you or someone else is at risk of serious harm, then I will be obliged to take appropriate action. This would be discussed with you before telling anyone else.

What are the benefits and risks of taking part?

You may not benefit personally from taking part in the research, but your participation will help to increase what is known about day centres and the people involved in them. To thank you for taking

part, you will receive a Certificate of Participation, and you may enjoy an event, or similar social activity, organised by the day centre with a donation I will give to express my gratitude.

If you feel upset or tired during an interview, we can stop for a break and turn off the voice recorder, end the interview and continue at another time, or you may choose to withdraw from the study.

I have been through checks for your safety.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a professional, who will have signed a confidentiality agreement. I will examine all the information collected for the study and produce articles, presentations and reports aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and my funder. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion (approved) by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on [EMAIL] [TEL] or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS or speak to me on [AGREED DAY].

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my main supervisor Professor Jill Manthorpe on:

[EMAIL] [TEL]

Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

6.4 Day centre staff

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people in your organisation. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The study aims to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects.

My name is Katharine Orellana. I am a student at King's College London and this research is for my PhD study.

Why have I been approached?

[NAME OF DAY CENTRE] has agreed to be involved in this research. You are being invited to consider taking part because you are one of its frontline staff. Up to 6 volunteers and staff may take part in the study. I will also be interviewing staff, volunteers, older people and carers here and in other day centres.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. It is important for you to understand that this research is not linked in any way with the service provided by [NAME OF DAY CENTRE].

If you are interested, I will explain the study and go through this Information Sheet with you. You can ask if anything is unclear. If you agree to take part, I will ask you sign a Consent Form. An interview will then be arranged. This can be carried out at a convenient time and place for you and will last about 50 minutes. With your permission, I would like to record the interview, in which I would ask you about you, your work, anything you get out of working at the day centre and what you think people get out of attending.

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you decide not to take part or decide to withdraw from the study, this will not affect the service provided by [NAME OF DAY CENTRE] or your work there in any way. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me. What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or area. Please understand, however, that if you tell me something that indicates that someone is at risk of serious harm, then I will be obliged to take appropriate action. This would be discussed with you before telling anyone else.

What are the benefits and risks of taking part?

You may not benefit personally from taking part in the research, but your participation will help to increase what is known about day centres and the people involved in them. To thank you for taking part, you will receive a Certificate of Participation, and you may enjoy an event, or similar social activity, organised by the day centre with a donation I will give to express my gratitude.

If you feel upset or tired during an interview, we can stop for a break and turn off the voice recorder, end the interview and continue at another time, or you may choose to withdraw from the study.

I have been through checks for your safety.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a professional, who will have signed a confidentiality agreement. I will examine all the information collected for the study and produce articles, presentations and reports aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and my funder. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion (approved) by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on [EMAIL] [TEL] or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS or speak to me on [AGREED DAY].

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my main supervisor Professor Jill Manthorpe on:

[EMAIL] [TEL]

Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

6.5 Day centre managers, trustees, owners

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people in your organisation. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The study aims to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects, although there is some evidence about the impact of day centres on people who attend and their carers. This research is for my PhD study.

Who is doing the research, who is sponsoring it and who is funding it?

My name is Katharine Orellana and I am carrying out this research. I am a full-time student at King's College London. My supervisors are Professor Jill Manthorpe and Professor Anthea Tinker. The study is being sponsored by King's College London and funded by The Dunhill Medical Trust which is a UK charitable company. The Trust has had no connection with the tobacco industry for many years. One type of research grant it gives is for trainee researchers.

Why have I been approached?

[NAME OF DAY CENTRE] has agreed to be involved in this research. You are being invited to consider taking part because you are its manager, owner or a trustee. Up to 6 volunteers and staff may take part in the study. I will also be interviewing other people here and at other day centres – older people who attend, carers, staff and volunteers.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. It is important for you to understand that this research is not linked in any way with the future of [NAME OF DAY CENTRE].

If you are interested, I will explain the study and go through this Information Sheet with you. You can ask if anything is unclear. If you agree to take part, I will ask you sign a Consent Form. An interview will then be arranged. This can be carried out at a convenient time and place for you and would last about an hour and three quarters. With your permission, I would like to record the interview, in which I will ask you about your role, the service you believe your day centre offers, how you see its fit within the market of social care and its relationships with local NHS community and health services. I would like to know about the day centre's funding, its users and any plans for the future. I am also interested in generic information your day centre holds about service users and how it is used, as well as any other background

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you decide not to take part or decide to withdraw from the study, this will not affect you or your day centre in any way. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me. What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or area. Please understand, however, that if you

tell me something that indicates that someone is at risk of serious harm, then I will be obliged to take appropriate action. This would be discussed with you before telling anyone else.

What are the benefits and risks of taking part?

You may not benefit personally from taking part in the research but your participation will contribute to improving the research evidence. The findings may help your organisation with future planning. The day centre will be given a donation to organise a group event, or similar social activity, as an expression of my gratitude for the cooperation. You will also be invited to attend a seminar at which general findings will be shared and your contributions sought to recommendations emerging from the findings. This will be an opportunity to influence policy and practice at local and national level. You will be given a report of the findings of the whole study.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a professional, who will have signed a confidentiality agreement. I will examine all the information collected for the study and produce articles, presentations and reports aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and my funder. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion (approved) by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033]. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on [EMAIL] [TEL or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my primary supervisor Professor Jill Manthorpe on:

[EMAIL] [TEL]

Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

6.6 Commissioners

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people in your organisation. Only participate if you want to. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The purpose of the study is to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects, although there is some evidence about the impact of day centres on those who attend and their carers. This research is for my PhD study.

Who is doing the research, who is sponsoring it and who is funding it?

My name is Katharine Orellana and I am carrying out this research. I am a full-time student at King's College London. My supervisors are Professor Jill Manthorpe and Professor Anthea Tinker. The study is being sponsored by King's College London and funded by The Dunhill Medical Trust which is a UK charitable company. The Trust has had no connection with the tobacco industry for many years. One type of research grant it gives is for trainee researchers.

Why have I been approached?

A day centre for older people in your area has agreed to be involved in this research.

I am inviting you to consider participating in this study as a commissioner of services for older people or to nominate potential participants. One of the study's aims is to discover how day centres are perceived by commissioners and why they have these perceptions.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. If you are interested, I will explain the study and go through this Information Sheet with you and you will be able to ask questions. If you agree to take part, I will ask you sign a Consent Form. I will then inform you which day centre is participating in the research and ask you to keep confidential the fact that it is participating in a research study.

An interview will then be arranged which would last about 45 minutes. With your permission, I would like to record the interview, in which I will ask you about your personal perspectives of the role and purpose of day centres, whether you commission any and why, their fit within the health and social care market and what user data you think day centres could collect that may be helpful in making commissioning decisions.

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me. What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or geographical area in which you work.

What are the benefits and risks of taking part?

Your participation will contribute to improving the research evidence. The findings could increase awareness of the purpose of day centres and have the potential to inform commissioning decisions. You will be invited to attend a seminar at which general findings will be shared and your contributions sought to recommendations emerging from the findings. A report of the findings of the whole study will be offered to your organisation.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a transcriber, who will have signed a confidentiality agreement. All notes made will be written up. I will examine all the information collected in detail using computer analysis programmes and produce articles, presentations and reports based on this work aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and Dunhill Medical Trust which has funded it. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on {EMAIL} [TEL] or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my primary supervisor Professor Jill Manthorpe (contact details below).

[EMAIL] [TEL]

Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

6.7 Signposters/referrers

I would like to invite you to take part in a research project about day centres for older people. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and discuss it with other people in your organisation. Only participate if you want to. Please ask if there is anything that is not clear or if you would like more information.

Why is the research being done?

The purpose of the study is to improve the understanding of the role and purpose of day centres for older people, how they are viewed and the context in which they are used. Little is known about these subjects. This research is for my PhD study.

Who is doing the research, who is sponsoring it and who is funding it?

My name is Katharine Orellana and I am carrying out this research. I am a full-time student at King's College London. My supervisors are Professor Jill Manthorpe and Professor Anthea Tinker. The study is being sponsored by King's College London and funded by The Dunhill Medical Trust which is a UK charitable company. The Trust has had no connection with the tobacco industry for many years. One type of research grant it gives is for trainee researchers.

Why have I been approached?

A day centre for older people in your area has agreed to be involved in this research.

I am inviting you to consider participating in this study as a professional who may signpost or refer to day centres or to nominate potential participants. One of the study's aims is to discover how day centres are perceived by such professionals and why they have these perceptions.

Do I have to take part? What does taking part involve?

It is up to you to decide whether to take part. If you are interested, I will explain the study and go through this Information Sheet with you and you will be able to ask questions. If you agree to take part, I will ask you sign a Consent Form. I will then inform you which day centre is participating in the research and ask you to keep confidential the fact that it is participating in a research study.

An interview will then be arranged which would last about 35 minutes. With your permission, I would like to record the interview, in which I will ask you about your personal perspectives of the role and purpose of day centres, whether you signpost or refer to these and why and your view of their fit within the health and social care market.

What will happen if I don't want to carry on with the study?

You may refuse to answer any question, stop the interview at any time, and are free to withdraw from the study at any time without giving a reason. If you wish to withdraw, please tell me. If you wish to withdraw after being interviewed, you can contact me up to two weeks afterwards and ask me not to use the information you have given.

Will taking part in the study be kept confidential?

Everything you say will be written down, stored securely and will be strictly confidential. Nobody will be told anything you have shared with me. What you say may be used in publications or presentations, but you will not be named, and neither will the day centre or geographical area in which you work.

What are the benefits and risks of taking part?

Your participation will contribute to improving the research evidence. The findings could increase awareness of the purpose of day centres and have the potential to inform signposting/referring

decisions. You will be invited to attend a seminar at which general findings will be shared and your contributions sought to recommendations emerging from the findings. A report of the findings of the whole study will be offered to your organisation.

What happens to the information you collect and to the results of the study?

The interviews will be typed up by a transcriber, who will have signed a confidentiality agreement. All notes made will be written up. I will examine all the information collected in detail using computer analysis programmes and produce articles, presentations and reports based on this work aimed at different audiences, including older people's and carers' organisations, policy-makers, practitioners, academics and Dunhill Medical Trust which has funded it. You will not be identified in any publication or presentation. Any direct quotations from interviews I use in my PhD thesis, publications or reports will be made anonymous. All personal information will be stored securely for 7 years after the study has ended and then destroyed.

Ethics?

This study has been reviewed and was given a favourable opinion by the Social Care Research Ethics Committee (Ref no. 15/IEC08/0033). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I would like to take part?

If you have any questions, would like to discuss any concerns or if you would like to take part in this research, please contact me, Katharine Orellana, on [EMAIL] [TEL or (postal address) Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

If I need to, who do I contact to report problems or complain about the research?

If you have any problems or concerns about the research or how it has been carried out, you can contact my primary supervisor Professor Jill Manthorpe (contact details below).

[EMAIL] [TEL]

Postal Address: Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS.

Appendix 7 Consent forms

7.1 Older attenders of day centres



**Institute of
Gerontology**



Consent form – attenders

Day Centres for Older People

Social Care Research Ethics Committee Ref: XXXX

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick	Yes	No
I have read and understood the information sheet dated [DATE] (version) for the above study. I have had the opportunity to consider the information and to ask questions which have been answered to my satisfaction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know I do not have to answer all the questions and can stop at any time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know that deciding not taking part in this research will not affect any services or care I am currently receiving.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I agree that you may use quotations from my answers and know that my name will not be used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I agree that my interview may be recorded so that what I say can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the study.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

*When completed, 1 form for Participant, 1 to be kept as part of the study documentation
See overleaf for confidentiality agreement by support person (if applicable)*

Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS
Tel: 44+(0)20 7848 1782 Fax: 44+(0)20 7848 1866 Email: scwru@kcl.ac.uk Website: www.kcl.ac.uk

Day Centres for Older People v1

Consent form – attenders

version 2 28.5.15

Confidentiality agreement - support person:

Please tick **Yes** **No**

I am attending this interview to support the person who has signed the Consent Form overleaf.		
I agree to maintain the confidentiality of what I hear at this interview.		

Signature of support person	Print name	Date
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7.2 Carers

Consent form - carers

Day Centres for Older People

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick	Yes	No
I have read and understood the information sheet dated [DATE] (version) for the above study. I have had the opportunity to consider the information and to ask questions which have been answered to my satisfaction.			
I know I do not have to answer all the questions and can stop at any time.			
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.			
I understand that deciding not to take part will not affect any services I am currently receiving, or the services the person I look after or help is currently receiving.			
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.			
I agree that you may use quotations from my answers. I know that my name will not be used.			
I agree that my interview may be recorded so what I say can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.			
I agree to take part in the study.			

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

When completed, 1 form for Participant, 1 to be kept as part of the study documentation

This work is supported by
The Dunhill Medical Trust
(grant number: RTF59/0114)



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Tel: 44+(0)20 7848 1782 Fax: 44+(0)20 7848 1866 Email: scwru@kcl.ac.uk Website: www.kcl.ac.uk

7.3 Day centre volunteers

Consent form – frontline volunteers

Day Centres for Older People

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick	Yes	No
I have read and understood the information sheet dated [DATE] (version) for the above study. I have had the opportunity to consider the information and to ask questions which have been answered to my satisfaction.			
I know I do not have to answer all the questions and can stop at any time.			
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.			
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.			
I agree that you may use quotations from my answers. I know that my name will not be used.			
I agree that my interview may be recorded so what I say can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.			
I agree to take part in the study.			

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

When completed, 1 form for Participant, 1 to be kept as part of the study documentation

See overleaf for confidentiality agreement by support person (if applicable)

Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS
Tel: 44+(0)20 7848 1782 Fax: 44+(0)20 7848 1866 Email: scwru@kcl.ac.uk Website: www.kcl.ac.uk

Day Centres for Older People v1

Consent form – frontline volunteers

version 1 17.4.15

Confidentiality agreement - support person:

Please tick **Yes** **No**

I am attending this interview to support the person who has signed the Consent Form overleaf.		
I agree to maintain the confidentiality of what I hear at this interview.		

Signature of support person

Print name

Date	
-------------	--

7.4 Day centre staff

Consent form – frontline staff

Day Centres for Older People

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

Please tick Yes No

I have read and understood the information sheet dated [DATE] (version) for the above study. I have had the opportunity to consider the information and to ask questions which have been answered to my satisfaction.		
I know I do not have to answer all the questions and can stop at any time.		
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.		
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.		
I agree that you may use quotations from my answers. I know that my name will not be used.		
I agree that my interview may be recorded so what I say can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.		
I agree to take part in the study.		

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

When completed, 1 form for Participant, 1 to be kept as part of the study documentation

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The Dunhill Medical Trust
(grant number: RTF59/0114)



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7.5 Day centre managers, trustees, owners

Consent form – managers/trustees/owners

Day Centres for Older People

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick	Yes	No
I have read and understood the information sheet dated [DATE] (version) for the above study. I have had the opportunity to consider the information and to ask questions which have been answered to my satisfaction.			
I know I do not have to answer all the questions and can stop at any time.			
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.			
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.			
I consent to anonymised direct quotations from my interview being used.			
I agree that my interview may be recorded so what I say can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.			
I agree to take part in the study.			

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

When completed, 1 form for Participant, 1 to be kept as part of the study documentation

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7.6 Commissioners

Consent form – commissioners

Day Centres for Older People

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick	Yes	No
I have had the opportunity to consider the information sheet dated [DATE] (version), ask questions and have had these answered satisfactorily.			
I know I do not have to answer all the questions and can stop at any time.			
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.			
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.			
I consent to anonymised direct quotations from the interview being used.			
I agree to the interview being recorded so that my comments can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.			
I agree to take part in the study.			

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

When completed, 1 form for Participant, 1 to be kept as part of the study documentation

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7.7 Signposters/referrers

Consent form – professionals who may signpost/refer to say centres

Day Centres for Older People

Thank you for considering taking part in this research. If you have any questions, please ask before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick	Yes	No
I have had the opportunity to consider the information sheet dated [DATE] (version), ask questions and have had these answered satisfactorily.			
I know I do not have to answer all the questions and can stop at any time.			
I know that I can change my mind about taking part for up to two weeks after this interview without explaining why. I know that, if I do, any information I have provided will be destroyed.			
I know you will be using this information to write produce articles, presentations and reports. I know my name will not be used.			
I consent to anonymised direct quotations from the interview being used.			
I agree to the interview being recorded so that my comments can be typed up and used as research data. I know that the recording will be destroyed after it has been typed up.			
I agree to take part in the study.			

Signature of participant	Print name	Date
Signature of interviewer	Print name KATHARINE ORELLANA	Date

When completed, 1 form for Participant, 1 to be kept as part of the study documentation

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Appendix 8 Interview schedules

8.1 Older attenders of day centres

Interview 1 (of 2)

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions. Information sheet. Consent form. Explain that this is the first of a two-part interview (second part will be at a different time – of their choosing).

Part 2: Contextual information – what a usual week looks like (15-20 mins)

'We'll start by thinking about what a usual week looks like for you.'

Interviewer will produce an A3 print-out of a 'map of a usual week' (see separate document) divided into days of the week and morning, afternoon and evening. Interviewer will guide a conversation about what happens during what interviewees consider to be a 'usual' week for them and fill in the map. Anything fortnightly/monthly will be marked as such.

Aim: to cover all informal and formal support and activities: any care/support they receive (family, relatives, friends) or which they pay for [who from? how paid?], any activities they attend or are involved in, social/other visits received, outings etc.

Once everything seems to have been covered, interviewer will tell interviewee that they will look at it again together later on so there will be a chance to add anything else they remember during the interview.

Prompts:

- When do you come here? [one or several days & day / whole or part of day]
- Do you go to any other clubs or activities? [maybe church, shopping club, dominoes]
- Does a care worker go to your house to help you with getting dressed, meals etc?
- Does someone help you with shopping or to clean the house?
- Do you have any regular 'appointments'?
- Do you see family/friends?

Part 3: Why person attends, their experiences, outcomes and connections with other attenders outside the day centre (45 mins)

Interviewer explains that they'll start the recorder now [consent requested on consent form].

Explain that most questions are available on SHOWCARDS to make process easier for interviewee (give choice about use of these in this part of the interview).

1. **Can you tell me how you travel here?**
2. **Would you like to tell me what started you thinking about coming to a day centre like [NAME OF DAY CENTRE]?**

Prompts:

- What was going on in your life at the time?
- How did you find out about [NAME OF DAY CENTRE]?
- Did someone help you to choose [NAME OF DAY CENTRE]?
- Did any social workers, or other professional, play any part?
- Did you choose [NAME OF DAY CENTRE] instead of something else?
- Why was that?

3. **What did you think of day centres such as [NAME OF DAY CENTRE] some time ago, before coming here?**

Prompts:

- Had you ever come across them before?
- Could you ever picture yourself choosing to use one?
- Has your attitude changed since coming to [NAME OF DAY CENTRE]?

4. **Have you made any friends at [NAME OF DAY CENTRE] who you see, or are in touch with by phone, outside the day centre?**
Prompts:
- Do you see or speak to anyone who comes here on days you're not at [NAME OF DAY CENTRE]?
- 5a. **On a practical note, have you been given any information, got involved in other activities or used other services through [NAME OF DAY CENTRE]?**
I'm interested in things that you probably wouldn't have been able to find out about or wouldn't been in touch with if you hadn't been coming here/otherwise.
Prompt: e.g. information, advice, benefits, hearing aid batteries, toe nail cutting, bath, access to birthday card shop, Handyperson Scheme, hairdressing, bathing, other services/clubs e.g. bowls.
- 5b. **What, if anything, has changed for you as a result [of these]?**
6. **Can you tell me about how you've found the whole experience of coming here?**
Prompts:
- What was your first contact when you originally found out about it
- What it was like when you first joined
- What is your view of the activities (like / feel obliged to join in / choice etc)
- How you find the volunteers, staff and other members
- How do you feel about coming?
- Are there opportunities to be involved in the organisation/running (e.g. suggestion box, activity choices)?
7. **How do you pay for this day centre service? [If you don't pay: who pays the costs of the centre?]**
8. **If you were unhappy with anything, would you know what to do about it and would you feel comfortable bringing it up?**
9. **Would you recommend coming to [NAME OF DAY CENTRE] to friends, family or a newcomer to the area who is in a similar situation to yourself?**
10. **Would you say that coming here adds anything to your life?**
Prompts:
Do you get anything out of coming here that you feel you wouldn't get anywhere else?
→ Can you tell me a bit more about that?
- Is it good value for money?
11. **Please could you describe the two things you like best about coming to [NAME OF DAY CENTRE]?**
12. **Please could you describe the two things you like least about coming to [NAME OF DAY CENTRE]?**
Prompts:
- If you could change anything, what would that be?
- How are the activities decided upon?
- Is there a choice of food? Do you like it?
- Is transport reliable?
- Do you dislike anything? e.g. special days of units for different groups/conditions (*dementia, ethnic groups etc*) [i.e. matters of segregation]
13. **Do you plan to continue coming here? If not, why is that?**
14. **If you have a relative caring for you, do you think that you coming to [NAME OF DAY CENTRE] helps them in any way?**
15. **Is there anything else you'd like to tell me about [NAME OF DAY CENTRE]?**

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering those questions – everything they've said will be very helpful to research.

Re-visit map of week: interviewee to be asked if they're happy with it or would like to add anything.

Explain that there is one more part of the interview left for today

→ Ask if would like a comfort break / cup of tea first / cake/biscuits[happy to continue?].

Apologise for any repetition coming up – know addressed some of these areas already – but it's important for me to ask these questions – explain validated scale means question wording and order is fixed.

Part 4: Impact on social care-related quality of life – to be measured using validated scale (30 mins): Adult Social Care Outcomes Toolkit (ASCOT)– INT4

See Appendix 0 for ASCOT IN4.

Explain that there will be **SHOWCARDS** with options for each question.

Part 5: About the attender (10 mins)

Now I'd like to know more about *you*. [SHOWCARDS]

1. What is your date of birth?

2. What is your marital status?

- ☐ Married/civil partnership
- ☐ Separated/divorced
- ☐ Widowed/surviving partner in civil partnership
- ☐ Single [never married]

3a. Are you: ☐ Male ☐ Female

3b. Is your gender identity the same as the gender you were assigned at birth?

- ☐ Yes ☐ No ☐ Prefer not to say

4. I'm asking this to everybody, just to show that I've interviewed a range of people.

Can you tell me which of the options on this card best describes how you think of yourself?

Please just read out the number next to the description.

- ☐ Heterosexual / straight 1
- ☐ Gay / Lesbian 2
- ☐ Bisexual 3
- ☐ Other 4
- ☐ Prefer not to say 5

5. What are your living arrangements?

- ☐ with spouse/partner ☐ with adult child(ren) ☐ with another family member
- ☐ with friend ☐ alone ☐ in care home
- ☐ in sheltered housing / extra care housing
- ☐ other arrangements (please specify)

6. Is where you live:

- ☐ owner-occupied ☐ rented – privately ☐ rented – local authority / housing association
- ☐ other

7. When did you move to this area? / How long have you been living in this area?

8. Apart from your pension, do you receive Pension Credit or any other financial help?

- ☐ Pension Credit
- ☐ Housing Benefit
- ☐ Other

9. Can you tell me about your education? I realise it's been a long time since you left school, but if you outline what age you were when left school and if you did any sort of training afterwards that would be very helpful.

10. Do you have any health conditions or disability?

A disability is a physical or mental impairment which has a substantial long-term adverse effect on your ability to carry out normal day-to-day activities.

Yes ☐ No ☐ Prefer not to say ☐

If **yes**, which of the following apply to you?

- ☐ A long-standing illness or health condition e.g. diabetes, chronic heart disease, cancer, HIV, epilepsy
- ☐ Deafness or serious hearing impairment
- ☐ Blind, partially sighted – uncorrected by glasses
- ☐ A physical disability or mobility difficulties e.g. use wheelchair, crutches, difficulty using arms
- ☐ A mental health condition e.g. depression, anxiety disorder, schizophrenia
- ☐ A specific learning disability e.g. dyslexia, dyspraxia, ADHD
- ☐ A general learning disability (e.g. Down's syndrome)
- ☐ A social/communication difficulty e.g. Asperger's Syndrome, other autistic spectrum disorder
- ☐ A disability, impairment or medical condition that is not listed above. *Please specify:*

☐ Prefer not to say

11. Which of the following best describes your religion or belief:

- ☐ Christianity
- ☐ Islam
- ☐ Buddhism
- ☐ Sikhism
- ☐ Hinduism
- ☐ Judaism
- ☐ Atheism
- ☐ Rastafarianism
- ☐ No religion or belief
- ☐ Any other religious affiliation or belief
- ☐ Prefer not to say

12. Do you look after your partner, a relative or friend who is ill or disabled as their carer?

You are a carer if, for example, you are on hand 24 hours a day to provide care, arrange hospital appointments for someone, drop round each day to keep someone company or cook their dinner, visit a relative who lives far away once a month to see how they're doing.

You may have been caring for a person for a long time or temporarily helping them.

13. Which of the following ethnic groups listed do you belong to?

These ethnic classifications are the ones recommended by the Equality & Human Rights Commission and used in the 2011 Census.

White

- ☐ British
- ☐ English
- ☐ Scottish
- ☐ Welsh
- ☐ Irish
- ☐ Northern Irish
- ☐ Gypsy or traveller
- ☐ Any other – please state

Asian

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ British
- ☐ English
- ☐ Any other – please state

Black

- ☐ African
- ☐ Caribbean
- ☐ British
- ☐ English
- ☐ Any other – please state

Mixed or multiple ethnic origin

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other – please state

Any other ethnic origin

- ☐ Arab
- ☐ Any other – please state
- ☐ Do not wish to answer

Interview 2 (of 2)

Introduction/welcome. Consent form – re-visit Consent Form signed before Interview 1.

Explain that this part of the interview is to measure various things and will use validated scales which means the questions have set wording and are in a fixed order.

Emphasise that this is not an assessment, although parts of it may feel a bit like one.

Explain that most questions will be on a showcard to make it easier for interviewee (give choice about use of these in this part of the interview).

**Part 6: Well-being – to be measured using validated scale:
Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)**

See Appendix 0 for SWEMWB scale.

**Part 7: Frailty – to be measured using validated scale:
Edmonton Frail Scale (EFS)**

See Appendix 0 for EFS.

**Part 8: Social network type – to be measured using validated scale:
Practitioner Assessment of Network Type (PANT) – Wenger’s social network scale**

See Appendix 0 for PANT.

End of interview. Emphasise valued contribution. Explain next steps.

8.2 Carers

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions. Information sheet. Consent form.

'Please answer these questions from your own perspective. I want to collect your views only.'

Part 2: About the person you care for (5 mins)

What relationship to you is the person you support?

- ☐ Spouse/partner
- ☐ Brother/sister
- ☐ Parent/parent-in-law
- ☐ Another family member
- ☐ Friend

How often does the person you support attend [NAME OF DAY CENTRE]?

Details: _____

Part 3: Well-being – to be measured using validated scale: Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) (10 mins)

See Appendix 0 for SWEMWB scale.

* Interviewer will have a laminated SHOWCARD with the 5 categories to select from.

Part 4: Outcomes for carer of day centre attender (20 mins)

INTERVIEWER SWITCHES ON RECORDER, subject to permission

1. **Would you like to tell me what started you and the person you support thinking about using a day centre like [NAME OF DAY CENTRE]?**

Prompts:

- What was going on in your lives at the time?
- How did you either of you find out about [NAME OF DAY CENTRE]?
- Did someone help you to choose [NAME OF DAY CENTRE]?
- Did any social workers, or other professional, play any part?
- Did either of you choose [NAME OF DAY CENTRE] instead of something else?
- Why was that?

2. **Does [CARED-FOR PERSON] spending time at [NAME OF DAY CENTRE] help you?**

If yes, could you tell me a bit more about that?

3. **What you value most about [CARED-FOR PERSON] coming to [NAME OF DAY CENTRE]?**

Prompts:

- What do YOU get MOST out of [CARED-FOR PERSON] coming to the day centre - that you feel you couldn't get anywhere else?
- Can you tell me a bit more about that?
- Is it good value for money?

- 4a. **On a practical note, have you been given any information, got involved in activities or used other services through [NAME OF DAY CENTRE]?**

I'm interested in things that you probably wouldn't have been able to find out about or have had access to if [CARED-FOR PERSON] hadn't have been attending [NAME OF DAY CENTRE]?

Prompt: e.g. information, advice, benefits, carers support groups, other services

- 4b. **What, if anything, has changed for you as a result [of these]?**

5. **Is there anything that you would like to be different about [NAME OF DAY CENTRE] to make it better for you, what would that be?**

Please be clear that that I just want to know if there is anything; I am not promising delivery of any changes because this is a confidential conversation.

Prompts:

- Is transport reliable? [if it is there – If not, would transport help?]
- How you find the volunteers, staff and other members
- How do you find the opening times?
- How do you feel about [CARED-FOR PERSON] going there?
- Is there anything you dislike?

6. **How strongly would you recommend [NAME OF DAY CENTRE] to other carers in your situation?**

- ☐ Would recommend very strongly
- ☐ Would recommend quite strongly
- ☐ Would recommend
- ☐ Would not recommend

7. **Do you plan to continue using it? [If not, why is that?]**

8. **Is there anything else you'd like to tell me about what you get out of [CARED-FOR PERSON]'s use of [NAME OF DAY CENTRE]?**

Outcomes for cared-for person - carer's view:

9. **What would you say is the most important thing that [CARED-FOR PERSON] gets out of attending [NAME OF DAY CENTRE]?**

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering those questions – everything they've said will be very helpful to my research.

→ Ask if would like a comfort break / cup of tea first before continuing with rest of interview.

Apologise for any repetition coming up – know addressed some of these areas already – but it's important for me to ask these questions. Explain that question wording and order is fixed in the next set of questions.

Part 5: Outcomes – to be measured using validated scale (30 mins): Adult Social Care Outcomes Toolkit (ASCOT INT4 – carers)

See Appendix 0 for ASCOT INT4 Carers.

Introduction [see ASCOT INT for carers]. Explain that the questions will be **SHOWCARDS with options** for each question.

Part 6: About the carer (10 mins)

Now I'd like to know more about *you*. [SHOWCARDS]

1. **What is your date of birth?**

2. **What is your marital status?**

- ☐ Married/civil partnership
- ☐ Separated/divorced
- ☐ Widowed/surviving partner in civil partnership
- ☐ Single [never married]

- 3a. **Are you:** ☐ Male ☐ Female

- 3b. **Is your gender identity the same as the gender you were assigned at birth?**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

4. **I'm asking this to everybody, just to show that I've interviewed a range of people.**

Can you tell me which of the options on this card best describes how you think of yourself?

[SHOWCARD]

Please just read out the number next to the description.

- ☐ Heterosexual / straight 1
- ☐ Gay / Lesbian 2
- ☐ Bisexual 3
- ☐ Other 4
- ☐ Prefer not to say 5

5. **What are your living arrangements?**

- ☐ with spouse/partner
 - ☐ with adult child(ren)
 - ☐ with another family member
 - ☐ with friend
 - ☐ alone
 - ☐ in sheltered housing / extra care housing
 - ☐ Other arrangements (please specify)
-

6. **Is where you live:**

- ☐ owner-occupied
- ☐ rented - privately
- ☐ rented – local authority / housing association
- ☐ other

7. **When did you move to this area? / How long have you been living in this area?**

8. **Apart from your pension, do you receive Pension Credit or any other financial help?**

- ☐ Pension Credit
- ☐ Housing Benefit
- ☐ Other

9. **Can you tell me about your education?** I realise it's been a long time since you left school, but if you outline what age you were when left school and if you did any sort of training afterwards that would be very helpful.

10. **Do you have any health conditions or disability?**

A disability is a physical or mental impairment which has a substantial long-term adverse effect on your ability to carry out normal day-to-day activities.

Yes ☐ **No** ☐ **Prefer not to say** ☐

If yes, which of the following apply to you?

- ☐ A long-standing illness or health condition e.g. diabetes, chronic heart disease, cancer, HIV, epilepsy
- ☐ Deafness or serious hearing impairment
- ☐ Blind, partially sighted – uncorrected by glasses
- ☐ A physical disability or mobility difficulties e.g. use wheelchair, crutches, difficulty using arms
- ☐ A mental health condition e.g. depression, anxiety disorder, schizophrenia
- ☐ A specific learning disability e.g. dyslexia, dyspraxia, ADHD
- ☐ A general learning disability e.g. Down's syndrome
- ☐ A social/communication difficulty e.g. Asperger's Syndrome, other autistic spectrum disorder
- ☐ A disability, impairment or medical condition that is not listed above. *Please specify:*

☐ Prefer not to say

11. Which of the following best describes your religion or belief:

- | | | |
|--|--|--|
| <input type="checkbox"/> Christianity | <input type="checkbox"/> Islam | <input type="checkbox"/> Buddhism |
| <input type="checkbox"/> Sikhism | <input type="checkbox"/> Hinduism | <input type="checkbox"/> Judaism |
| <input type="checkbox"/> Atheism | <input type="checkbox"/> Rastafarianism | <input type="checkbox"/> No religion or belief |
| <input type="checkbox"/> Any other religious affiliation or belief | <input type="checkbox"/> Prefer not to say | |

12. Which of the following ethnic groups listed do you belong to?

These ethnic classifications are the ones recommended by the Equality & Human Rights Commission and used in the 2011 Census.

White

- | | | | | |
|---|---|---|--------------------------------|--------------------------------|
| <input type="checkbox"/> British | <input type="checkbox"/> English | <input type="checkbox"/> Scottish | <input type="checkbox"/> Welsh | <input type="checkbox"/> Irish |
| <input type="checkbox"/> Northern Irish | <input type="checkbox"/> Gypsy or traveller | <input type="checkbox"/> Any other – please state | | |

Asian

- | | | | |
|----------------------------------|------------------------------------|---|----------------------------------|
| <input type="checkbox"/> Indian | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> British | <input type="checkbox"/> English | <input type="checkbox"/> Any other – please state | |

Black

- | | | | |
|---|------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> African | <input type="checkbox"/> Caribbean | <input type="checkbox"/> British | <input type="checkbox"/> English |
| <input type="checkbox"/> Any other – please state | | | |

Mixed or multiple ethnic origin

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African | <input type="checkbox"/> White and Asian | <input type="checkbox"/> Any other – please state |
|--|--|--|---|

Any other ethnic origin

- | | |
|--|---|
| <input type="checkbox"/> Arab | <input type="checkbox"/> Any other – please state |
| <input type="checkbox"/> Do not wish to answer | |

Thank and emphasise that interviewee has made a much valued contribution. Hope they have enjoyed the experience of being involved in a research project. Explain next steps.

8.3 Day centre volunteers

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions. Information sheet. Consent form.

'Please answer these questions from your own perspective. I want to collect your views only.'

Part 2: Outcomes (30 mins)

INTERVIEWER SWITCHES ON RECORDER, subject to consent.

1. **When did you start volunteering at [NAME OF DAY CENTRE]?**
2. **How often do you volunteer here? How many hours a week do you give?**
3. **Would you like to tell me how you came to be volunteering at [NAME OF DAY CENTRE]?**
Prompts:
 - Why did you want to volunteer?
 - What was going on in your life at the time?
 - How did you find out about [NAME OF DAY CENTRE]?
 - Why did you choose [NAME OF DAY CENTRE]?
 - Had you worked with older people before?
4. **Please could you describe to me the two things you like best about volunteering at [NAME OF DAY CENTRE]?**
5. **Do you feel that volunteering here adds anything to your life?**
Prompts:

Do you get anything out of coming here that you feel you wouldn't get anywhere else?

→ Can you tell me a bit more about that?
6. **Would you recommend volunteering at [NAME OF DAY CENTRE] to friends, family or a newcomer to the area who is in a similar situation to yourself?**
7. **Do you plan to continue volunteering at [NAME OF DAY CENTRE]? [If not, why is that?]**
8. **If you could change anything about [NAME OF DAY CENTRE] to make it better for you, what would that be?**
Prompts:
 - How you find the volunteers, staff and other members
 - Is there anything you dislike?
9. **Do you volunteer anywhere else? Where/how often?**
10. **What would you say that the older people who come to [NAME OF DAY CENTRE] get out of coming?**
11. **Is there anything else you'd like to tell me about [NAME OF DAY CENTRE]?**

Part 3: About the frontline volunteer (10 mins)

Now I'd like to know a little bit about *you*.

1. **What is your date of birth?**
2. **What is your marital status?**

<input type="checkbox"/> Married/civil partnership	<input type="checkbox"/> Separated/divorced
<input type="checkbox"/> Widowed/surviving partner in civil partnership	<input type="checkbox"/> Single [never married]
- 3a. **Are you:** ☐ Male ☐ Female
- 3b. **Is your gender identity the same as the gender you were assigned at birth?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prefer not to say
------------------------------	-----------------------------	--

4. **I'm asking this to everybody, just to show that I've interviewed a range of people.**
Can you tell me which of the options on this card best describes how you think of yourself?
[SHOWCARD]

Please just read out the number next to the description.

- ☐ Heterosexual / straight 1
☐ Gay / Lesbian 2
☐ Bisexual 3
☐ Other 4
☐ Prefer not to say 5

5. **What are your living arrangements?**

- ☐ Live with spouse/partner
☐ Live with adult child(ren)
☐ Live with another family member
☐ Live with friend
☐ Live alone
☐ Live in sheltered housing / extra care housing
☐ Other arrangements (please specify) _____

6. **Do you have any health conditions or disability?**

A disability is a physical or mental impairment which has a substantial long-term adverse effect on your ability to carry out normal day-to-day activities.

Yes ☐ No ☐ Prefer not to say ☐

If yes, which of the following apply to you?

- ☐ A long-standing illness or health condition e.g. diabetes, chronic heart disease, cancer, HIV, epilepsy
☐ Deafness of serious hearing impairment
☐ Blind, partially sighted – uncorrected by glasses
☐ A physical disability or mobility difficulties e.g. use wheelchair, crutches, difficulty using arms
☐ A mental health condition e.g. depression, anxiety disorder, schizophrenia
☐ A specific learning disability e.g. dyslexia, dyspraxia, ADHD
☐ A general learning disability e.g. Down's syndrome
☐ A social/communication difficulty e.g. Asperger's Syndrome, other autistic spectrum disorder
☐ A disability, impairment or medical condition that is not listed above. *Please specify:*

☐ Prefer not to say

7. **Which of the following ethnic groups listed do you belong to?**

These ethnic classifications are the ones recommended by the Equality & Human Rights Commission and used in the 2011 Census.

White

- ☐ British ☐ English ☐ Scottish ☐ Welsh ☐ Irish
☐ Northern Irish ☐ Gypsy or traveller ☐ Any other – please state

Asian

- ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ British ☐ English ☐ Any other – please state

Black

- ☐ African ☐ Caribbean ☐ British ☐ English
☐ Any other – please state

Mixed or multiple ethnic origin

- ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other – please state

Any other ethnic origin

- ☐ Arab ☐ Any other – please state
☐ Do not wish to answer

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering those questions – everything they've said will be very helpful to research. Hope they have enjoyed the experience of being involved in a research project. Next steps.

8.4 Day centre staff

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions.

Information sheet – either read out or check that participant has read it.

Consent form – go through it and ask participant to sign it (if haven't already done so).

Please answer these questions from your own perspective. I want to collect your views only.

Part 2: Outcomes (30 mins)

INTERVIEWER SWITCHES ON RECORDER, subject to consent.

1. **When did you start working at [NAME OF DAY CENTRE]?**
2. **Are you full-time or part-time?**
How many hours a week do you work here?
3. **What do you do here?**
4. **Would you like to tell me how you came to be working at [NAME OF DAY CENTRE]?**
Prompts:
 - Had you worked with older people before?
 - How did you find out about [NAME OF DAY CENTRE]?
 - Why did you apply to [NAME OF DAY CENTRE]?

Please could you describe to me the two things you like best about working at [NAME OF DAY CENTRE]?

6. **Do you feel that working here adds anything to your life?**
Prompt: Do you get anything out of working here that you feel you wouldn't get elsewhere?
→ **Can you tell me a bit more about that?**
7. **Would you recommend working at a day centre like [NAME OF DAY CENTRE]?**
8. **Do you plan to continue working here? [If not, why is that?]**
9. **What would you say that the older people who come to [NAME OF DAY CENTRE] get out of coming?**
10. **Is there anything else you'd like to tell me about working at [NAME OF DAY CENTRE]?**

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering those questions – everything they've said will be very helpful to research.

Part 3: About the frontline staff member (10 mins)

Now I'd like to know a little bit about *you*.

1. **Can you tell me if you've done any training related to this work, either in this job or before?**
If you have any qualifications, what are they and in what year did you qualify?
- 2a. **Are you:** ☐ Male ☐ Female
- 2b. **Is your gender identity the same as the gender you were assigned at birth?**
☐ Yes ☐ No ☐ Prefer not to say

3. **Which of the following ethnic groups listed do you belong to?** These ethnic classifications are the ones recommended by the Equality & Human Rights Commission and used in the 2011 Census.

White

- ☐ British ☐ English ☐ Scottish ☐ Welsh ☐ Irish
☐ Northern Irish ☐ Gypsy or traveller ☐ Any other – please state

Asian

- ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ British ☐ English ☐ Any other – please state

Black

- ☐ African ☐ Caribbean ☐ British ☐ English
☐ Any other – please state

Mixed or multiple ethnic origin

- ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other – please state

Any other ethnic origin

- ☐ Arab ☐ Any other – please state
☐ **Do not wish to answer**

4. **Were you born in the UK?** **If not, when did you come to the UK?**
5. **What is your date of birth?**

Thank for much valued contribution. Hope they have enjoyed the experience of being involved in a research project. Next steps.

8.5 Day centre managers, trustees, owners

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions. Information sheet. Consent form.

'Please answer these questions from your own perspective. I want to collect your views only.'

Part 2: Local relationships, views on their day centre, funding, plans for the future (60-80 mins)

INTERVIEWER SWITCHES ON RECORDER, subject to consent

1. What is your current role at [NAME OF DAY CENTRE]

2. When did you start at [NAME OF DAY CENTRE]?

3. What did you do before?

Prompt:

- If you were working/volunteering at [NAME OF DAY CENTRE], what did you do and how long for?
- What sector did you work in and in what role?

4. In your view, what potential outcomes does [NAME OF DAY CENTRE] offer?

Prompts:

-to older users, to carers of users,
-to volunteers ... -... (to staff?)
- ... to commissioners [e.g. targets, box ticking, addressing local strategies]
- ... to professionals who refer or signpost to it

5. In your view, does [NAME OF DAY CENTRE] have a particular 'unique selling point'?
Could you expand on this?

5b. In your view, does [NAME OF DAY CENTRE] offer 'added value' somehow?
Could you expand on this?

6. How do you think [NAME OF DAY CENTRE] fits within the market of social care service provision?

Prompts:

- What is the relationship with social services (e.g. referrals, partnership)?
- What do you see as its place within the system? e.g. is it a 'standard' service?
- Do people attend using Direct Payments, Managed Personal Budgets or Individual Service Funds?
- How do you see it in relation to policies around 'personalisation' of services?

7a. What, if any, relationship does [NAME OF DAY CENTRE] have with community, primary and secondary NHS care services?

By these, I mean services offered by the health system such as district nursing, community mental health teams, podiatry, reablement, audiology, medicines management and GPs.

[SHOWCARD WITH THESE EXAMPLES LISTED].

Prompts:

- What services are provided at [NAME OF DAY CENTRE] for its users? (e.g. hearing aid maintenance, toe nail cutting, health checks, therapy, talks about health,)
- Do any health professionals attend [NAME OF CENTRE] regularly? Why?
- How would you describe your relationship with local community nurses, mental health teams, GPs, occupational therapists? (e.g. referrals, signposting) (*Prompts:* non-existent, cooperative etc).

7b. What impact do you believe this/these relationship(s) has?

Prompts:

- ...on outcomes for older people and carers?
- ...on the health and social care system?
- Is any impact relevant to local targets or national policy?
- Do you have any evidence of impact?

8. Please can you explain how [NAME OF DAY CENTRE] is funded?

Prompts:

- Grant/contract
- Direct payments, Individual Service Funds (older people's or carers')
- Fundraising (as a subsidy?)
- How is it costed so you know how much needs to be charged?
- Is everyone charged the same amount?
- Do people pay in advance or on the day?
- Do you have an annual 'membership' fee?
- What sort of implications does this arrangement have on the stability or viability of [NAME OF DAY CENTRE]?

9. Has the way [NAME OF DAY CENTRE] is funded changed significantly in the last five years? If yes, has this impacted on what is provided? How?

10. Has there been a big change in the type and numbers of people who use [NAME OF DAY CENTRE] in the last five years?

Prompts:

- type of people - short term attendance, higher needs, localism etc
- numbers of people - waiting list, unfilled places

11. Can you tell me about your plans for the future?

12. In general, can you outline what information you have about individual attenders of [NAME OF DAY CENTRE]?

Examples: - Assessment at start; - Care/support plan (?) –by day centre and/or social services;
- Referral info; - Any other documentation that they think may be relevant/of value

Prompts:

- How is it gathered?
- When is it gathered?
- Who provides it?
- How is it updated?
- When is it updated? (e.g. regular reviews)

13. Could you explain to me how [NAME OF DAY CENTRE] uses this information?

Prompts:

- Who has access to it?
- Is any detailed or overview data made available to outside bodies?
 - If yes, could you please outline what this is and to whom it is provided?
- Is data used for planning purposes? (e.g. planning activities, fundraising)
 - If yes, what data and how is it used?
- Is data analysed to identify trends over time?

14. I'm also interested in background information about the day centre. Would you be able to let me have any documentation that you think could be of value to this study? What documentation are you able to provide me with, or let me know about if it's available online?

Examples: [SHOWCARD]

- Statement of Aims / Objectives (charity register / company registration)
- Statement of target beneficiaries (charity register / company registration)
- Funding bid/tender documentation
- Internal reports to the Board/owner/managing company/charity/local authority
- Annual report(s)
- Internal and/or external evaluations
- Reports of user satisfaction
- Schedules of activities / if days are for different clientele etc
- Any other documentation that participant thinks may be relevant/of value

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering those questions – everything they've said will be very helpful to research.
Hope they have enjoyed the experience of being involved in a research project. Next steps.

8.6 Commissioners

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions.

Information sheet.

Consent form – go through it and ask participant to sign it (if haven't already done so).

'Please answer these questions from your own perspective. I want to collect your views only.'

Part 2: Perceptions of day centres (35 mins)

INTERVIEWER SWITCHES ON RECORDER, subject to consent.

Background questions:

How long have you been in the role of commissioner in [LOCAL AUTHORITY/CCG]?

What are you responsible for? (e.g. older people, all adults etc)

What was your previous role?

1. Do you/does [LOCAL AUTHORITY/CCG] commission or fund any day centres for older people or any places at day centres?

If YES → Can you expand on the reasons for this?

Prompts:

- Can you tell me about the types of day centre do you commission or fund? (e.g. level of need, target users)
- How do you commission/fund them? (e.g. block purchase, using Managed Personal Budgets, via Individual Service Funds, partial core funding, open invitations to tender?)
- Are these day centres openly accessible, by referral only or a mix of these?
- Is transport included?

If no → Can you expand on the reasons for this?

→ Did you ever commission day centres? If yes → why did you stop?

2. Can you tell me about your opinions of the purpose and role of day centres for older people?

Prompts:

- Thinking particularly about people *with no, or with low, cognitive impairment*, do you think they offer older people anything particular?
- *Why* do you think older people use day centres and why do they *not* go to them?
- Do you think some groups of older people use day centres more than others? Why is that?
- Do you think day centres contribute to any local commissioning targets or strategies (e.g. JSNA – Joint Strategic Needs Assessment)? *(please can you expand?)*
- Do you think day centres fit with today's policy agenda? *(Prompt: wellbeing, early intervention, support for carers, personalisation). (Please can you expand?)*

3. In addition to their regular activities, day centres may also offer assessments, benefit checks, hearing aid maintenance (changing batteries and cleaning), bathing, toenail cutting and access to preventive services such as handyperson schemes. Some people believe that day centres play an important role within health and social care, and that they are very relevant to the Care Act 2014. Others see them as outdated and expensive.

What, if anything, do you think day centres offer, or have the potential to offer, the health and social care market?

Prompts:

- Is there a role for day centres for older people in supporting the delivery of integrated care?
- Do you commission any of these separately to be run in a day centre?
- What kind of relationships do you see day centres as currently having with community, primary and secondary services?
- Do you think there is any potential for development in this area? *If yes, could you expand on this?*

5a. In your view, does [NAME OF DAY CENTRE] have a particular 'unique selling point'?

If yes, what would you say that is?

5b. In your view, does [NAME OF DAY CENTRE] offer 'added value' somehow?

If yes, what would you say that is?

6. Thinking about data about day centre users, is there any data about users that may be helpful when making commissioning decisions and, in your view, day centres could collect?

Prompt: e.g. frailty, well-being, outcomes (validated scales)

7. Is there anything else you'd like to share with me about day centres for older people?

Prompts:

- Any upcoming plans/reviews?

- Any reports that may give me a better understanding of the approach taken by [LOCAL AUTHORITY/CCG]?

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering those questions – everything they've said will be very helpful to research.

Thank for much valued contribution. Hope they have enjoyed the experience of being involved in a research project. Next steps.

8.7 Signposters/referrers

Part 1: Opening introductions, information and consent (10 mins)

Opening introductions.

Information sheet.

Consent form – go through it and ask participant to sign it (if haven't already done so).

'Please answer these questions from your own perspective. I want to collect your views only.'

Part 2: Perceptions of day centres (25 mins)

INTERVIEWER SWITCHES ON RECORDER, subject to consent.

Background questions:

Role:

Employing organisation:

How long have you been in this role?

What was your previous role?

1. Do you signpost or refer to day centres for older people?

If YES → Do you signpost, refer or both?

Can you expand on the reasons for this?

Prompts:

- What types of day centre do you signpost or refer to? (e.g. level of need, target users)
- Can you tell who you signpost/refer to day centres? (*Prompt: older people/carers?*)
- Can you tell me in what circumstances you signpost/refer to day centres?
- Do you reach people who don't contact you for an assessment?
- (If GP) Have you made 'social prescriptions' for day centre use?
 - If yes, could you talk a bit more about this?
 - If no, why is that? (*Prompt: Have you heard of 'social prescriptions'?*)

If NO → Can you expand on the reasons for this?

2. Can you tell me about your opinions of day centres for older people and their purpose?

Prompts:

- Thinking particularly about people *with no, or with low, cognitive impairment*, what do you think they offer the older people who attend?
- *Why* do you think older people use day centres and why do they *not* go to them?
- Do you think some groups of older people benefit from using day centres more than others?
- Do you think day centres contribute to any local commissioning targets or strategies (e.g. JSNA – Joint Strategic Needs Assessment)?
- Do you think day centres fit with today's policy agenda? (*Prompt: wellbeing, early intervention, support for carers, personalisation*)

3. In addition to their regular activities, day centres may also offer holistic assessments, benefit checks, hearing aid maintenance (changing batteries and cleaning), bathing, toenail cutting and access to preventive services such as handyperson schemes. Some people believe that day centres play an important role within health and social care. Others think they are old-fashioned and expensive.

What, if anything, do you think day centres offer, or have the potential to offer, the health and social care market?

Prompts:

- Could day centres for older people support the delivery of integrated care?
- What kind of relationships do you see day centres as currently having with community, primary and secondary services?
- Do you think there is any potential for development in this area?
- If yes, could you expand on this?

4a. In your view, does [NAME OF DAY CENTRE] have a particular 'unique selling point'?

If yes, what would you say that is?

4b. In your view, does [NAME OF DAY CENTRE] offer 'added value' somehow?

If yes, what would you say that is?

5. Could you tell me about anything you think has influenced your views about day centres for older people?

Prompts:

- Are you aware of any evidence related to day centres? Could you expand on this? (*Prompts: what was the source of the evidence/where did you find it, what type of evidence is it?*)?

- Do you have a local network which informs your decisions? How does this work?

6. Is there anything else you'd like to share with me about day centres for older people?

INTERVIEWER SWITCHES OFF RECORDER

Thank for answering the questions – everything they've said will be very helpful to research.

Hope they have enjoyed the experience of being involved in a research project. Next steps.

Appendix 9 List of useful organisations provided to attenders



Institute of
Gerontology



Useful organisations

Day Centres for Older People

Age UK National Advice Line	0800 169 6565 (open 365 days) Provides information and advice about many different subjects. Age UK supports and assists a network of more than 170 local Age UKs throughout England and can put you in touch with your local organisation. Each Age UK is an independent charity that works to promote the wellbeing of people in later life.
Alzheimer's Society National Dementia Helpline	0300 222 1122 (Mon-Wed 9am-8pm; Thur-Fri 9am-5pm; Sat-Sun 10am-4pm) Provides information, support, guidance and signposting to other appropriate organisations.
Bereavement Advice Centre	0800 634 9494 (Mon-Fri 9am-5pm except bank holidays) Provides advice on practical matters to deal with when someone dies.
Bladder and Bowel Foundation Helpline	0845 345 0165 (24hrs – leave your name and number and a nurse calls back Mon-Fri 9am-5pm, Sat mornings) Free and confidential helpline staffed by trained continence nurses who offer support and advice.
Carers UK Adviceline	0808 808 7777 (Mon-Fri 10am-4pm) Provides information and advice on: benefits and tax credits; carers employment rights; carers' assessments; services available for carers; how to complain effectively and challenge decisions.
Citizens Advice Bureau	08444 111 444 Provides information on your rights – including benefits, housing and employment, and on debt, consumer and legal issues.
Cruse Bereavement Care Helpline	0844 477 9400 (Mon & Fri 9.30am-5pm; Tues-Thurs 9.30am-8pm, except bank holidays) Provides support for people after the death of someone close.
Diabetes UK Careline	0345 123 2399 (Mon-Fri 9am-7pm) Helpline for people with diabetes, their friends, family, carers and healthcare professionals.

Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS
Tel: 44+(0)20 7848 1782 Fax: 44+(0)20 7848 1866 Email: scwru@kcl.ac.uk Website: www.kcl.ac.uk

Day Centres for Older People v1

Useful organisations

version 1 17.4.15

FirstStop Advice	0800 377 7070 (Mon-Fri 9am-5pm) Free service which aims to help older people, their families and carers get the help or care they need to live as independently and comfortably as possible. Information about housing, care or finance is provided by the Elderly Accommodation Counsel.
Grandparents Plus	0300 123 7015 (mon-Fri 10am-3pm) Champions the role of grandparents and the wider family in children's lives, especially when they take on the caring role in difficult family circumstances.
Macmillan Support Line	0808 808 00 00 (Mon-Fri 9am-8pm) Information and support from cancer nurse specialists.
Macular Society Helpline	0300 3030 111 Provides information, advice, guidance and support for people with macular conditions like age-related macular degeneration (AMD).
Mind InfoLine	0300 123 3393 (Mon-Fri 9am-6pm except bank holidays) Provides information on a range of topics including: types of mental health problem; where to get help; medication and alternative treatments; advocacy.
NHS 111	111 (24 hours, 365 days) For urgent medical help or advice (not life-threatening situations); if you need health information or reassurance about what to do next; if you don't know who to call or don't have a GP to call (e.g. if you're feeling down or anxious).
Relate	0300 100 1234 Provides relationship support and counselling in England, Wales and Northern Ireland. Counselling sessions are paid for – costs depend on the counsellor. There's also a free telephone counselling service.
The Samaritans Helpline	08457 90 90 90 (24 hours a day, 365 days a year) Talk any time you like about whatever's getting to you. You don't have to be suicidal.
SilverLine	0800 4 70 80 90 (24 hours, 365 days) Free confidential helpline providing information, friendship and advice to older people.
Stroke Helpline and Information Service	0303 3033 100 (Mon-Friday, 9am to 5pm) Information for people who have been affected by stroke in any way.

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Appendix 10 Certificates of participation

Certificates of participation were printed on heavyweight (145gsm) parchment-style A4 certificate paper.



Appendix 11 Tables of literature included in literature review (Chapter 4)

SHADED ONES ARE ENGLAND / UK
Significant=statistically significant
DC=day centre
OP=older

Evidence table - literature about day centres or attenders (46)

Author/date, Country Publication	Aims <i>Day centre model</i>	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
PERCEPTIONS							
Fitzpatrick and McCabe (2008) Canada Peer-reviewed journal <i>Activities, Adaptation and Aging</i>	To discuss challenges senior centres will face in maintaining and designing programs that address services and activities suitable for more active adult groups such as the baby boomers. <i>Senior centre (Multipurpose model)</i>	None	N/A	<u>Literature review</u> Non-exhaustive. Dates and search strategy not specified.	Discusses challenges for senior centres with reference to baby boomers.	Fitzpatrick and McCabe found limited literature in this area. Relevant to this review, they concluded that day centres ' <i>are already a traditional part of our culture and are widely recognized and respected</i> ' (p211).	More a discussion than a review of literature. Dates and search strategy not specified.
Hostetler (2011) US Peer-reviewed journal <i>Journal of Aging Studies</i>	To explore how senior centre employees conceptualise their work and organisational mission. <i>Senior centres</i>	None.	Part of larger qualitative assessment of services aiming to identify matches & mismatches between current services and anticipated goals/needs of younger OP aged 55-65. ----- <u>Interviewed</u> : 30: 23 DC directors (managers) , or senior staff, and 7 regional, national or umbrella service providing organisations; 4 interviews were with 2 participants. <u>Participant observation</u> in 1 centre.	<u>Qualitative</u> Interviews. Observation over 2 years (incl. 3 further interviews with staff & 1 with director)	Unstructured interviews explored: - if/how concepts of community and individual/consumer choice were used to describe work and shape service provision - goals & visions for DCs & how day-today operations reflect these. Interviewees asked about services offered, attenders, relationships and referrals between organisations, whether there were unmet needs for resources/services and 'wish lists' for the future. DC activities & visitor tours observed, staff meetings attended and written materials read (e.g. newsletters). In this phase, interviewees were asked about purpose of their work & motivations/goals guiding it. Themes identified based on commonly-used words.	Marketing had become important in an environment of individual choice in which the future needs/preferences of younger OP who are healthier and more active than previous cohorts of same age group. Managers and their senior staff believed that DCs suffered from an image problem which meant they may fail to attract younger and more active OP without more activities, space, transport, volunteers and staff. They recognised the potential risks of focusing their attention on this group at the expense of oldest attenders with highest needs when such centres have traditionally been cross-generational. Wish lists for new activities often included the type of activity that may appeal to younger OP. It was noted that DCs were for OP without personal care support needs or dementia which is counter to a mission of serving the whole community. Was a small amount of criticism of DCs concerned their role in giving OP 'the choice to remain (potentially isolated) in their own homes' (p171).	US context differs from that in England.
MaloneBeach and Langeland (2011) US Peer-reviewed journal <i>Journal of</i>	To investigate baby boomers' vision of their retirement, any services they expected to use and any preferred alternatives. <i>Senior centres.</i>	None.	Randomly selected from registered voters in 1 county. ----- 225 people aged 50-59 (225) 29% response rate. (Sample 800 – 40 undeliverable; 2.1% of total number of voters).	<u>Qualitative</u> Survey (postal)	Respondents completed a 24 item survey asking people: - to imagine their changing needs as they aged and state what services would improve their satisfaction with leisure activities - to identify which services (selected from a given list) they expected to use. Survey specifically asked about perceptions of their local 'senior center'	Senior centres were perceived, firstly, as a place for social engagement and, secondly, as a place for activities. 29% (67) reported enjoying group activities and 68% (153) said they would be happy to use one. Almost all (44%, n=99 of 49%, n=110) those worried about future caring responsibilities said they would use services that supported them as carers, such as senior centres. Preference expressed for multi-purpose (not segregated) centres. Civic engagement was of great interest, with 31% already volunteering and 96% expecting their civic engagement to increase after retirement. MalneBeach & Langeland's interpretation: Declining use of DCs not due to negative perceptions or decreasing interest, but because ageing baby boomers are not joining	Respondents possibly not representative (very high education) - rural area with industrial town hiring well-educated people. Funded by evaluation budget of providers of services. (unspecified) to OP and a university

Author/date, Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
<i>gerontological social work</i>	<i>Day centre model</i>				(image of it and service offerings, fees and funding, clientele).	as fast as attenders are leaving due to lack of needs. Clear preference for non-segregated centres and desire for continuity suggests promotion of multipurpose/community centres.	grant, survey wording may have been positively biased.
Sale (2005) England Sector press	Looks at how day centres may need to re-invent themselves in order to survive.	N/A	N/A	Opinion piece	Discusses reinvention of day centres and considers what makes a good day centre.	Notes that views about DCs are very polarised in professionals and individuals. Includes a case study of an 88 year old woman who had previously been active. Five years earlier, she had reluctantly started to attend a DC on the advice of her doctors. Her initial negativity was replaced with enthusiasm after only 3 weekly visits, and she went on to attend twice a week. She recounted a visit to her aunt's residential home which, she believed, had resulted in her negative view of DCs. This account suggests, albeit anecdotally, that changed individual circumstances may result in changes to perceptions of DCs.	Discussion relates to all client groups, not just older people.
ATTENDERS' CHARACTERISTICS							
Al-Dosseri <i>et al.</i> (2014) Bahrain Peer-reviewed journal <i>Bahrain medical bulletin</i>	To estimate the prevalence of depression among elderly attending day care centres. Day Care Centre	None	All 7 DCs in Bahrain ----- Attenders (254) ≥60 Mean age: 65.5	<u>Quantitative</u> Interview (validated scale) 2010	Socio-demographic and health data collected. Geriatric Depression Scale (GDS-15) - shorter version – administered. Statistical analysis carried out.	Depression was prevalent among attenders. On the GDS, 41.7% (n=106) scored as depressed. Within this group significant risk factors for depression were being female, living with a partner or being illiterate. People who were widowed or lived alone had a higher level of depression than others. People with chronic disease had lower levels of depression than those without. Being female, illiterate and living with a partner were important predictors of depression.	Almost half of all attenders in country participated, but findings cannot be generalised to all attenders. Bias may have resulted from interviewing by different doctors.
Boen <i>et al.</i> (2010) Norway Peer-reviewed journal <i>Scandinavian journal of public health</i>	To determine what were the socio-demographic, psychosocial and health characteristics of people who used senior centres compared with people who did not. <i>Senior Centre.</i>	None	Randomly selected from Norwegian Population Register in 2 Oslo districts. ----- Older people (2,387) – attenders and non-attenders living in the community (numbers of each not given). 111 of 4,000 excluded as lived in institutions, survey sent to 3,889. Of 3,889, 166 had unclear living arrangements & were withdrawn. Of remaining 3,723, 2,934 of 3,723 returned survey (64%). 7 removed as incomplete.	<u>Quantitative</u> Survey (postal)	Data collected: - Psychological ailments (Hopkins Symptom Checklist (HSCL-10) measuring anxiety & depression) - Psychosocial: social support (Oslo-3 Social Support Scale (OSS-3)). - Health & QoL: health now; how satisfied with life. Diagnoses of diabetes, chronic lung disease, osteoporosis, musculo-skeletal ailments, coronary infarction, angina, stroke & cancer. - Knowledge of DCs. If a regular user, 'now & then' user or non-user of DCs: - Reasons for not using DCs - Frequency of different activities (watching TV, reading, walking, travelling cultural activities, visiting others). Socio-demographic (incl. income & education) & psychosocial goals. Goals for health and satisfaction. Statistical analysis undertaken.	Statistical analysis controlling for different variables showed the highest groups of users were the oldest men and women (≥80), single women aged 70-79, women with a diagnosis of osteoporosis, and men (aged 70-79) and women (aged 65-79) with a memory impairment. Usage declined with increased education, income and social support, but this was a tendency not a significant indicator. People aged ≥80 were the most common attenders. DC attendance increased with age and particular health problems, a group with more health problems and less income than younger groups. (Characteristics of the two groups are not presented separately, only comparisons.) Although social support was measured, this was not reported on separately, but used to create a profile of day centre attenders compared with non-attenders.	Despite high response rate & large sample size representative of DCs' target groups, non-responders may have been the most needy and older women who were poorly represented. - highest non-response rates at older ages ≥80s (43%), 70-79 (37%). Sample characteristics given by gender and area - not known how many attended DCs.
Iecovich and Carmel (2011) Israel	To identify individual predisposing, enabling, and need characteristics that differentiate between users and nonusers of day	Andersen's behavioural model	National stratified sample + convenience sample of DC users. ----- 333 OP: - 81 DC attenders	<u>Quantitative</u> Interview (face-to-face)	Socio-demographic and other data collected were grouped according to Anderson's model: Predisposing factors: age, gender, marital status, years of residence in Israel, education.	DC attenders were significantly more likely to be younger or unmarried, live alone, less education, lived longer in the country, better functional status, better self-reported health and larger family networks than non-attenders but less contact with them. People with smaller family networks were significantly less likely to attend a DC. Receiving home care significantly decreased the likelihood of DC attendance DC	Non-random sampling.

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Peer-reviewed journal: <i>Journal of Applied Gerontology</i>	care centres for frail older persons Day care centres		- 252 non DC attenders (20% of whom had cognitive impairment). All recipients of home or day care under Long-Term Care Insurance. Only significant difference between groups: convenience sample was younger (79 compared with 89). Mean age 80.7 (attenders), 86 (non-attenders)		Enabling factors: economic status, size of family network, frequency of contact with family members, living arrangements and if had a homecare worker Need factors: ADLs, IADLs and self-rated health. Statistical analysis were undertaken.	[but the sample was mainly HC recipients]. 71% of DC attenders also had home care. People with more IADL limitations were less likely to attend a DC than those with less IADL limitations. Iecovich and Carmel interpret this as suggesting that DCs serve socially vulnerable OP but only moderately frail OP (who can still enjoy social activity) rather than OP with poorer function and health as per their aim.	
Judge <i>et al.</i> (2010) UK (Scotland) Peer-reviewed journal <i>Journal of Policy and Practice in Intellectual Disabilities</i>	To gather participants' views on 'retirement' at 65 and to explore their experiences of broader daytime activity. <i>Local authority day centres for people with <u>learning disabilities</u> <65</i>	None.	Convenience (identified via community learning disability service) ----- 16 long-term <i>attenders</i> of DCs, aged 41-64, with mild to moderate learning disabilities and would be expected to 'retire' (i.e. cease to attend, be 'discharged') when they reached the age of 65.	<u>Qualitative</u> Interview (face to face)	Participants asked for some information about their current routine, then invited to talk as widely about their experiences and about the feelings, attitudes, and beliefs related to these. An interpretative phenomenological approach was used to analyse data.	Participants highly valued their DCs as the social hub of their communities. DCs were places they could be occupied, active, eat lunch and meet their friends (other attenders and staff). They were of the view that they would be isolated and lack purpose if they didn't attend their DC. There was a strong desire for continuity and a lack of understanding as to why they didn't get a choice about whether to continue attending once they reached 65. Participants were concerned about losing full membership of their community and the consequences of this. They also valued their independence and autonomy. <i>Included here as people with learning disabilities are living to older ages - usually considered to have reached old age around the age of 50 due to a tendency to develop health problems at younger ages.</i>	Small sample, but in-depth. Generalisability limited (semi-rural) particularly if different systems operate. Already 'retired' people ≥65 omitted; participants were anticipating retirement, not experiencing it. Being interviewed in DC may have influenced some responses, but was most convenient location for them.
Manthorpe and Moriarty (2014) England Peer-reviewed journal <i>Health and Social Care in the Community</i>	To identify what is known about how congregate day care or day centres will meet the challenges posed by the Equality Act 2010 in supporting older people who are lesbian, gay, bisexual and transgender, or from minority ethnic groups.	Equality	N/A	<u>Scoping review of UK literature</u> No date restrictions imposed. Carried out May 2013.	Searched: - Databases: AgeInfo, Embase, Medline, PsycINFO, Social Care Online, Web of Science. - Publication platform: Ingenta Connect. - Older people's sites.	There is a lack of UK research about all aspects of congregate day services. Gaps include who DCs help, how and under what circumstances. OP appear to value the opportunities provided by DCs. DCs promote positive outcomes and support people's health, nutritional, social and daily living. Few evaluations identified; some may have been published as grey literature & others remained unpublished with service providers. Few UK studies acknowledged the over-representation of women. Manthorpe & Moriarty: 1) - highlighted the difficulties associated with collecting evidence on an undefined 'intervention' or series of non-standard interventions, 2) - emphasised the centrality of cost-effectiveness.	Perspective of access to services from an equalities perspective
Pardasani (2010) US Peer-reviewed journal <i>Activities, Adaptation and Aging</i>	To document the characteristics of current senior centre participants and examine the factors that influence participation decisions among older adults. <i>Senior centre</i>	None	Purposive Mailing list of 3,500 consumers provided by the local 'Area Agency on Aging' (NWICA). ----- Older people (1,283) - 56% attenders (722) - 44% non-attenders (563). Response rate: 36%	<u>Quantitative</u> Survey (postal)	Survey (developed by Pardasani with an advisory group) of 26 questions (21 multiple choice, 5 open-ended). Option for face-to-face assistance to complete it offered. Data collected: demographic characteristics; nature, pattern and degree of participation in DCs among users; reasons for participation/non-participation.	DC still have an important place in continuum of care, but will need to adapt to survive – particularly those which are publicly funded as funding and attendance are linked. Predictors of attendance: age, gender, income, living arrangements, mobility, carer/grandparent responsibilities. Majority of attenders were white, lived alone and had low incomes. Attenders less likely to be disabled (if older) and not to be informal carers. Less likely to attend: BME older people, employed or married people, those with higher incomes and frail people with disabilities. There was a curvilinear relationship between age & attendance (i.e. attendance increases with age, drops off <u>significantly</u> with increasing frailty).	US context differs from that in England.

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					Survey also acted as a needs assessment tool for NWICA. Descriptive statistics & statistical analysis.	Pardasani noted greying of participant pool and potential for attracting baby boomer generation (e.g. by offering volunteering opportunities which younger older people are keen on).	
Santangelo <i>et al.</i> (2012) Italy Peer-reviewed journal <i>Archives of Gerontology and Geriatrics</i>	To determine the health conditions of OP attending one DC by recording their medical history and evaluating their cognitive and affective states, and levels of autonomy and ability to self-care. <i>Elderly Health Observation Day Centre</i>	None (aim was to evaluate health with a view to creating similar DCs in every district in the area)	No account of how individuals were recruited and what proportion of overall numbers of attenders were represented. ----- Attenders (42) of 1 DC. Mean age: 73.6. 50% lived alone; 50% with a family members, usually spouse.	Quantitative Questionnaire (administration unspecified)	2-part questionnaire: - gathered detailed medical history - evaluated cognitive & affective spheres, and levels of autonomy & self-sufficiency using: – Mini-Mental State Examination (MMSE) - Geriatric Depression Scale (GDS) - ADLs, IADLs, and the physical performance test (PPT) Descriptive statistics.	Comorbidities were prevalent (73.7% had these). 62% took 4 or more medications. Despite this, 55% were fully independent in ADLs and IADLs, 33% were slightly dependent and only 12% highly dependent. 50% of sample were cognitively impaired, although 23.17% only mildly. Sensory impairments: 40.5% visual; 45.1% hearing. Very common: osteoarthritis (92.8%), hypertension (61.8%), cardiovascular disease (47.5%), diabetes (26.2%). Fewer were depressed at 6 month follow-up compared with baseline (54.8% down to 47.5%).	No recruitment details. No account of how medical histories were taken or whether these were verified was provided - relevant since a quarter of participants were more than mildly cognitively impaired.
Savard <i>et al.</i> (2009) Canada Peer-reviewed journal <i>Journal of Aging and Health</i>	To examine factors related to regularity of adult day centre attendance among older people with functional limitations. <i>Adult Day Care</i>	Enhanced Andersen Behavioural Model (i.e. predisposing characteristics & need factors), to include aspects of service delivery	System of Integrated Care for Older Persons (SIPA), evaluated a model of integrated services for frail OP Jun 1999 - Mch 2001, recruiting 1,230 participants through 2 service providers. ----- Attenders (101) of 5 DCs in 1 big city. Aged ≤65 needing ADL/IADL assistance and living in the community, and who attended day centres attended a DC for 6-month period during the larger study.	Quantitative Sub-set of questionnaire data collected by interview as part of a larger study (SIPA) between May-Nov 2000.	Questionnaires, including one to primary carers, administered by interview collected characteristics of OP and carers. Data on attendance for 6 month period. Statistical analyses of data.	More regular attendance (as a proportion of scheduled days) by OP with functional limitations was <i>significantly</i> associated with: - receiving ADL/IADL assistance on DC attendance days - attending for a whole day not than half a day - participating less in prevention & health promotion activities once at DC - having a carer experiencing a higher level of burden (where <i>no</i> cognitive impairment) or lower level of burden (where cognitive impairment) - not having worked, or having a carer who had not worked, in health care sector (the only <i>significant</i> predisposing factor associated with attendance which Savard <i>et al</i> speculated may indicate university education is associated with lower DC attendance.) Context for study: attendance rates of 4/5 DCs in study 64-85% (average 73%).	Not random sample, although broadly representative but catchment area more ethnically diverse. Reliable comparison hindered by lack of standardised group activity classification. Spousal carers (associated with higher attendance) over-represented. 33% cognitively impaired –but findings separated.
OUTCOMES							
Aday <i>et al.</i> (2006) US Peer-reviewed journal <i>Journal of Women & Aging</i>	To examine how friendships made within and extending outside day centres, and activities participated in, influenced the health and wellbeing of older women living alone. <i>Multipurpose senior centre.</i>	None	Purposive Selected from the original 734 whose data had been collected by the NISC survey. ----- Female older attenders (415) who had participated for at least 1 year in activities at multi-purpose DCs and lived alone (274) or with a spouse (171). Mean age: 74 No differences between groups in self-assessed health status, health status cf 1 yr before, frequency of doctor visits, chronic health	Quantitative (case control) Secondary analysis of data drawn from a comprehensive 2002-03 survey carried out by the National Institute of Senior Centers (NISC) (type of survey unspecified).	Data collected about: - Life satisfaction: 8 choices in response to question about how everyday life has changed since participating in DC education & health promotion activities (incl. emotional wellbeing e.g. worry less about future, feel less lonely) - Impact of DC on mental health: ‘Coming to the center makes my mental health’ (much better, a little better, no different, worse).” - Geriatric Depression Scale – short version. - Social support network & its strength measured by questions about perceived & actual emotional & instrumental support (e.g. depend on friends etc) - Opportunities for strengthening social	DCs may act as locations in which women, particularly those living alone, may develop supportive social networks which impact positively on their mental wellbeing. 67.3% perceived that their mental health had considerably improved since going to the DC. Greater improvements for those living alone (for 71%, mental health had very much improved) than those living with a spouse. Emotional wellbeing: 50% of whole sample laughed more than before, 47% felt less lonely, 43% felt more satisfied with life. Those living alone less likely to be depressed if had friends they perceived they could rely on. <i>Significantly</i> greater improvement in life satisfaction for women living alone than married; with <i>significantly</i> greater improvements in 5 of 8 life satisfaction measures: felt less lonely, laugh more, worry less about future, have more energy and cope with stress better. Of those living alone: 89% had developed close friendships – with an average of 12.48 special friends each; 84% felt emotionally supported by these friends; 53% reported confiding in new friends; - 84% felt that their new friends would help them if they were in need (e.g. transport, shopping).	Non-random selected sample means limited generalisability, but large sample size counteracts this to an extent. Cross-sectional: does not consider how friendship patterns may have shifted over time. Method of data collection unspecified.

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			conditions or no. of medications used, or in depression status.		ties with new friends measured by 8 questions about specific activities (e.g. go out to eat, go shopping together). - DC activity participation (seen as central to developing networks) – checklist completed (educational, life skills, arts/recreation, health promotion, support groups, and volunteer activities). Comments stressing importance of DC friendships captured qualitatively.	Having friends gave people a sense of belonging. For some, they were 'substitute family members' (p68). Some said that such companionship protected them from loneliness and isolation. Some, who were housebound, said they would go to the DC more often were transport available. Women reported enjoyed the companionship they found at the centres (e.g. 'the joy of simple conversation' p68). Developing a strong social support network was more important for the emotional wellbeing of women living alone than for married women. Both groups were similar in terms of friendship formation, perceptions of support and emotional depth to friendships made. 94% attended weekly. Living alone stayed longer (3.4 cf 3.1 hrs).	
Bilotta <i>et al.</i> (2010) Italy Peer-reviewed journal <i>European Journal of Ageing</i>	To find out whether attending a day centre was associated with quality of life in community-dwelling older people with depression. <i>Day Care Centre</i>	None	Purposive Selected from 643 assessed during 4 month period at 1 geriatric unit. 5 of 154 eligible unwilling (87% participation) ----- Older people (149) - at least once weekly attenders (17) - non-attenders (132) All ≥70 with diagnosed depression, and without dementia, severe sensory impairment, personality disorder or psychosis. Mean age: 82 Groups similar in age, functional & emotional status, comorbidity and social conditions e.g. living alone, no. of visiting relatives).	Quantitative Interview 2008	Comprehensive geriatric assessment including: - ADL/IADL status - balance & gait: Performance-Oriented Mobility Assessment (POMA) - cognitive status: Mini Mental State Examination (MMSE) - emotional status: 30-item Geriatric Depression Scale (GDS) - morbidity: Cumulative Illness Rating Scales (CIRS-m and CIRS-s) Subjective health-related QoL: European Quality of Life Visual Analogue Scale (EuroQoL VAS) Objective determinants of QoL used for analysis: clinical, functional & emotional status, mobility and cognitive function. Statistical analysis comparing attenders with non-attenders.	Found associations between DC attendance and higher QoL in depressed OP living in the community compared with non-attenders. QoL was even higher with higher weekly attendance. None of non-attenders had ever attended DCs which Bilotta <i>et al</i> interpreted as suggesting that depressed OP tend not to drop out of DCs. Bilotta <i>et al</i> believe the findings are 'of a reasonable magnitude' (p33) taking into account the similar prevalences of depression and dementia and that most DC attendees have dementia.	Small number of attenders (11% of sample). More of a medical model (incl nurses, OTs, physio) despite similar purpose to UK non-medical model. Causality cannot be determined by cross-sectional study.
Caiels <i>et al.</i> (2010) England UK Social care research Group	To develop and validate an approach to measuring the impact of low-level services on service users, specifically day care centres.	Cost-effectiveness based on valued consequences	Random selection 137 DCs providers from list of 497 provided by 31 of 150 LAs who responded to survey. (100 randomly selected; 37 added to meet target for distribution of 5,000 individual recruitment packs – mean 37 per provider). ----- Older attenders (961) low level preventive DCs. All ≥65 and with sufficient cognitive function to consent and participate in face-to-face interview. 19% response rate (of 5,000 recruitment packs). Mean age: 81	Quantitative (Validation and testing reliability of an impact measure) Self-completion questionnaire (961) Interview (224) which included a validated scale	Tool to measure impact of a service in terms of valued consequences/outcomes (social care-related quality of life) in 9 domains was tested and validated (ASCOT). Questionnaire: individual characteristics & need, outcomes. Those consenting were interviewed to test reliability/ validity of questionnaire (collected same data & additional outcomes questions, demographics & dependency measures - EQ5D validated scale - health outcomes (mobility, self-care, usual activities, pain/discomfort, anxiety/ depression); a single (global) QoL measure using a -point scale; ADLs & IADLs; a single (global) health measure using 5 point scale. Statistical analysis undertaken. Tool included intangible aspects likely to be affected by DCs (e.g. having a good social life, being meaningfully occupied & feeling	DCs impacted positively in all 9 domains: - greatest impact was for outcomes associated with social contact (61% of respondents) - next greatest benefits were for meals and home cleanliness & comfort (40%) (' <i>This may be due to reducing the tasks associated with food preparation and personal cleanliness that would otherwise take place at home</i> ' (p37). Attendees benefiting most were those either attending >3 times a week, living alone, receiving Pension Credit (lower income) or with higher ADL needs (but not very high ADL needs i.e. 5 ADLs). The higher needs, the greater the outcomes improvement, except at the highest need levels. DCs were cost-effective if guidance used by NICE to judge cost-effectiveness of health services relative to outcomes is applied. Attendance at DCs improved outcomes at a cost equivalent to just under £25,000 per annum per 0.1 unit improvement (ASCOT scale of 0-1) per attendee on average. There was a 92% probability that DCs were cost-effective at a £30,000 per ASCOT threshold. 61% very satisfied with support received from DC, 31% quite satisfied, 5% neither satisfied nor dissatisfied, 3% quite/very dissatisfied. 80% always happy the way care workers treat them, 16% usually happy, 3% sometimes happy.	Risk of bias in sample as administered by DC providers but whether sample was representative could not be established as no national data on DC users available.

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	<i>Day centre model</i>		Interview: 262 consented, 38 dropped out (moved, unavailable, ill, poor cognition, died, hospitalised, inadequate English) leaving 224.		in control) and tangible aspects (personal cleanliness, home cleanliness & comfort, safety, meals and nutrition) as well as anxiety, dignity & respect. People rated their QoL/wellbeing in these 9 domains, both current and hypothetical (expected in absence of DC). Research-based importance weights used to calculate a score showing impact.	62% said that those offering support/assistance at DC always did the things they wanted done, 29% nearly always, 9% sometimes, 1% never. 77% said that those offering support/assistance always do a good job, 20% usually, 2% sometimes, 1% never. 63% rated relationship with people offering support/assistance as excellent, 32% good, 5% okay. 72% attended the DC as much as they wanted, 26% would like attend more, 1% visited more than they wanted to.	
Dabelko-Schoeny and King (2010) US Peer-reviewed journal <i>Journal of Gerontological Social Work</i>	This study aimed to reveal the impact of ADS from the perspective of the participant to identify new areas for outcomes research in ADS. <i>Adult Day Health Service</i>	None.	Purposive ----- Attendees (28) with little/no cognitive impairment – 90 days after enrolment – in 4 day health centres. 4 of 32 interviews excluded due to inaudible recordings (3) & too great cognitive impairment (1).	Qualitative Interviews 2005-06	Semi-structured interviews gathered descriptions of the ways in which attendance made a difference to their lives (incl. their favourite thing about going to the DC). MMSE administered after interview to determine cognitive status. Grounded theory approach taken to analysis. Categories identified & grouped into themes using theoretical coding. A conceptual model was developed.	Attending a DC had made a difference to 25 respondents' lives; 3 enjoyed attending, but said it had made no difference to their lives. The most impactful experiences were: - social connections with other attendees - participation and/or enjoyment of activities and being able to access the services provided (arts, games, exercise, learning new things and physio/occupational therapy). Second most impactful were relationships with staff that empowered attendees (e.g. by acknowledging attendees' feelings, giving them choices and helping them to learn new skills.) These experiences improved perceived psychosocial wellbeing (reduced social isolation and feelings of depression & anxiety) and perceived dependency & burden on carers (carer did not have to worry about them, and this improved their relationship). Social connections with other attendees ranged from simply having people to talk to or making new friends. Sitting at shared tables during informal and formal activities was an important chance to make connections. Having people to talk with also helped people to gain better perspective of their own abilities. Dabelko-Schoeny & King argued that: 1) - experiences appeared to be influenced positively by the fact that services were delivered in a group setting, 2) - findings suggest that psychosocial wellbeing can be better targeted by individual care planning & activity programming.	Acknowledged positive bias, but effect of this was mitigated by re-stating responses in interviews, monitoring recordings & regular de-briefs. Acknowledged weakness: single not repeat interviews, but efforts were made to reach data saturation by continuing to interview until multiple views, descriptions etc had been collected. Socially desirable responses may have been given.
Fawcett (2014) Australia Peer-reviewed journal <i>British Journal of Social Work</i>	To explore the relationship between day centre attendance, increased resilience and improved health and psycho-social outcomes. <i>Day Clubs</i>	None	Exploratory study - cross-section across region. ----- Attendees (80) of different day clubs	Mixed methods Validated scales Interviews	Variety of validated scales to measure outcomes. Most unspecified; Geriatric Depression Scale used. Interview content unspecified. 1 year follow-up carried out with 12.5% (n=10).	Attendance promoted wellbeing through improvements in resilience & mental health. A <i>strong relationship</i> between DC attendance and improved depression and resilience scores was found. The longer people attended, the more resilient and 'mentally buoyant' they became. All participants showed gains, people who benefited more: lived alone, mobility impaired, younger (≤70), attended for longer (more often or over longer period). People in 2 DCs were attendees on some days and volunteers on others. 89% felt more stimulated; 87% experienced a greater sense of contentment & 69% greater confidence; 81% made new friends. Attendance 'encouraged the undertaking of additional activities and engagement with family and community networks outside the club.' (p843): 56% undertook more outside activities than previously. Participants reported valuing ways that DCs enabled them to exercise self-direction and promote self-confidence' (p843). Fawcett speculated that: 1) - DCs appeared to have a role in reducing hospital admissions related to socially related health crises/ineffective health monitoring & in delaying institutionalisation for socio-health reasons, 2) - that those feeling no benefits	Very little reported about method, timescales and analysis (article based on unpublished report).

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	<i>Day centre model</i>					would be most likely to stop attending. Drop-out rates were low. Tried to contact former attenders to discover reasons; this was impracticable. At 1 year follow-up, findings showed continued positive impact in confidence, the ability to undertake more activities, greater feelings of security and reduced social isolation.	
Fitzpatrick <i>et al.</i> (2005) Canada Peer-reviewed journal <i>Social Work in Health Care</i>	To examine the influence of social support (friendship, caregiving and advice) on mental and physical health. <i>Senior Centre</i>	Social networks	Purposive – DCs selected based on comparable activity programmes and functional ability of attenders. - OP - inclusion based on participation in 4 activities: volunteering, lunch, card playing & dance. ----- Older attenders (186) of 2 large senior centres, 55% of whom volunteered there. 186 represented 81% of OP invited and approx. 90% of all attenders. Mean age: 72.5 (9 aged 47-62)	Quantitative Self-administered questionnaire including validated scales 2003	Questionnaire developed for study collected data about wellbeing, social support & health, length of attendance, participation in activities, demographics. Modified versions of scales used: - Psychological General Wellbeing Schedule (PGWB) (subjective) - Medical Outcomes Study Social Support Survey (social support & self-rated health) 'Caregiving' included help with chores if ill, prepare meals if unable to, take to GP, share private fears with, give hugs. Statistical techniques were used to establish influence of social support on mental & physical health, some of which may not normally be considered within 'social support'.	Participating in activities, volunteering and eating together at DCs promoted socialisation. Social support obtained at DCs benefits attenders' mental and physical health. Attenders starting a new activity perceived better health & social support from friendships. Despite 68% of participants reporting having at least 3 friends at DC, social support from friendship was <i>not</i> one of the factors that <i>significantly</i> affected health. Fitzpatrick <i>et al</i> reported being surprised by this. Attenders living alone perceived less support from friendship, were less happy with their life and felt their life was not full of interesting things compared with attenders living with someone. Those eating lunch at DC (31%) perceived less support from friendship & poorer physical health than people who did not, but it was not known if this was their only activity at the DC. Attenders who volunteered perceived better physical health & social support and more support from advice (at a personal level, e.g. confiding about problems, advice about crisis) than non-volunteers. Fitzpatrick <i>et al</i> speculated that people who lived alone - who reported life to be less interesting – may seek socialisation and support from peers and staff by attending DCs - 'the senior centre scene may represent the only meeting place for isolated and lonely people' [p34].	Only addressed 3 aspects of social support (friendship, caring & advice). Caregiving variable may have been confounded with having a spouse or social support outside the DC.
Fulbright (2010) US Peer-reviewed journal: <i>Journal of Psychiatric and Mental Health Nursing</i>	To determine the role that senior citizen centres play in decreasing depression in community-dwelling older persons. <i>Senior centre</i>	Social Cognitive Theory (self-efficacy component)	Convenience ----- 257 attenders of 9 senior centres. All were aged ≥55, with minimal or no cognitive impairment and did not take antidepressant medication.	Quantitative Questionnaire	Questionnaire collected demographic data (age, living arrangements, marital status, gender), length of time and reason for attending DC (meals, activities, friends/support), impact of attending the centre on everyday life (better, no change, worse), friendships (new DC friends & their reliability at DCs when in need of assistance, friends outside DCs & their reliability when in need of assistance. Validated screening tool used to measure depression - 15-point Geriatric Depression Scale.	DCs are places at which social networks can be developed. Attending a DC impacted positively on individuals and was said to deter depression. Of the factors noted to be linked with less reported depressive symptoms were perceived life improvement, making friends who could be relied on and making close friends, with the latter being the most <i>significant</i> . Having friends at DCs <i>significantly</i> lowered the odds of reporting depressive symptoms. 75% (n=193) perceived that attending a DC had improved their lives. Life had not changed for 23% (n=59) and was worse for 0.8% (n=2). Improvement was largely attributed to increased social support (by 80%). Of the 14% (n=36) showing symptoms of depression, 55.6% (n=20) said that life had improved since attending the DC. Most (69%, n=178) had started attending a DC for social support, a reason slightly more common among widows/ers (74%) than married people (69%) and was lower among those divorced/never married (59%). The meals had attracted 18% (n=47) and activities 12% (n=32). 88.2% (n = 178) of respondents who started attending for social support, 87.5% (n = 32) of those attracted by the activities and 74.5% of those attracted by the meals (n = 47) did not self-report depressive symptoms using the Geriatric Depression Scale (GDS-15). Depression was less reported by people having made close friendships at the DC compared with those who hadn't. 94% (n=241) had made close friends, most of whom (88%, n=212) experienced low depressive symptoms. 85% (n=217) said they could rely on these new friends. Of the few (6%, n=15) who had not made close friends, around half did and half did not report depressive symptoms. Although no data about length of attendance were reported, Fulbright concluded that 'the	Non random sampling limits generalisability of findings. Self-reported data. Possibly over-claims the impact on depression of attending DCs since the study's cross-sectional nature means that cause and effect cannot be established, although outcomes of making friends and life improvement. The findings, particularly with respect to outcomes for men were said to be important, however, only levels of depressive symptoms for men (41% of participants, n=100) were reported separately.

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	<i>Day centre model</i>					effect of attending the senior centre for periods long enough to make close friends reduced the numbers of older persons screening for depression by 4–5% [p390]. 93% (n=241) of participants reporting having friends outside the DC and 92% said they could rely on them.	
Iecovich and Biderman (2012) Israel Peer-reviewed journal <i>International Psychogeriatrics</i>	To investigate whether attenders reported reduced loneliness. 2012 <i>Day Care Centre (social model)</i>	Social needs theory Andersen et al's behavioral model	Purposive. Recruited through 13 DCs serving approx. 1,000 physically frail and cognitively intact OP. GPs identified a cognitively intact non-user for each attender. If non-user reluctant or unavailable, GP was asked to provide another name. ----- Older people ≥60 (817) - all frail with no cognitive impairment. - 417 attenders - 400 non-attenders Groups matched by age (within 5 years), gender & GP, ADL and IADL status. Attendees: further 165 refused, 75 not members of a specific health insurance organisation and unspecified number had language barriers, cognitive impairments or unavailable (around 60% of whole sample of attenders). Of non-attenders approached, 111 refused, 65 unavailable, 7 had died. No suitable match was found for 17.	Quasi-experimental (cross-sectional, case-control) Interviews administering scales (incl. validated) 2009-10	Structured, face-to-face interviews: - Loneliness (social & emotional): de Jong Gierveld Loneliness Scale (incl 11 items) - IADLs: Fillenbaum's measure - ADLs: Katz <i>et al's</i> instrument - Self-rated health: 1-6 rating scale - Comorbidity: if suffer from 14 major medical conditions (1 point for each) - Day care use: number of times attended per week (1-6) & length of time (months) attended - Economic status: 7 categories of income & perceived economic status (Likert scale of 1-5).	Differences in loneliness between attenders and non-attenders who were frail and not cognitively impaired were <i>not significant</i> , although loneliness was reported slightly more by attenders (moderate to severe loneliness: 79.3% of attenders, 76.3% of non-attenders). Frequency and length of DC attendance were <i>not significantly</i> associated with levels of loneliness. <i>Significant</i> factors in explaining loneliness in DC attenders were older age, poorer perceived economic status, self-rated health and IADL function and living in Israel for fewer years. These factors were also <i>significant</i> across the whole sample for which additional significant factors were having fewer children and living in smaller households. Despite finding that DCs did not exert a significant influence on levels of loneliness, Iecovich & Biderman speculated that their findings suggest that DCs may actually impact positively on loneliness if one bears in mind the differing predisposing factors, enabling factors and need between attenders and non-attenders, since those who attend may have been motivated to do so to alleviate their loneliness.	Causal relationships cannot be established by a cross-sectional study. Sample may not be representative of attenders across the country.
Iecovich and Biderman (2013a) Israel Peer-reviewed journal <i>The Journal of Applied Gerontology</i>	To explore and examine the reasons for use and non-use of day centres 2013a (reasons) <i>Day Care Centre (social model)</i>	None.	[See Iecovich & Biderman 2012] ----- Older people ≥ 60 (819) - 417 attenders - 402 non-attenders All frail with no cognitive impairment. Groups matched by age (within 5 years), gender & GP, ADL and IADL status.	[See Iecovich & Biderman 2012]	Structured face-to-face interviews: - Reasons for non-use: list of 20 reasons in 6 categories: awareness of service (3 items), accessibility barriers (4 items), current attenders' characteristics (4 items), DC's characteristics (4 items), 'no need for such a service' (3 items), personal difficulties (3 items). List based on interviews with 2 DC directors who provided reasons low DC attendance. - Reasons for use: list of 10 agree/disagree statements: 4 categories: promotes wellbeing (4 items), provides social benefits (2 items), meets needs (2 items), serves as respite for caregivers (2 items).	Most non-attenders (90%) reported ≥4 reasons for non-attendance rather than one main one. Almost all (97.2%) non-attenders reported being aware of the services. Most (84.7%) knew what it offered. Non-attenders reported their main reasons for not attending DCs as not needing such a service (90%) and preferring to stay at home (88%). Other reasons included finding it difficult to see disabled people, perceptions that only miserable people use DCs, uninteresting activities and problems with accessing them. Non-attenders did not identify with people who attended. Almost all attenders reported doing so to improve their life, mood, health and wellbeing, for social benefits, to feel less lonely and increase their friendship circles, as respite for their family and because the service met their needs. Half said they did so to reduce the burden on their family. Iecovich and Biderman suggest that non-attendance may be partly due to perceptions of DCs as being a service for people from lower classes (most attenders had low education levels) and partly due to social networks still being in place and, therefore, their 'need' was not for a socially-based service.	List of reasons did not allow for OP to provide additional, unanticipated reasons. Sample may not be representative of attenders across the country. Generalisation may be restricted to social models of DC. Undertaking interview at DC may have affected responses positively.

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					- Also IADLs, ADLs, self-rated health, co-morbidity, DC use and income (actual and perceived) [See Iecovich & Biderman 2012] Statistical analysis undertaken.		
Iecovich and Biderman (2013b) Israel Peer-reviewed journal <i>Ageing & Society</i>	To examine the extent to which attenders experience higher levels of quality of life than non-attenders <i>Day Care Centre (social model)</i>		[See Iecovich & Biderman 2012] ----- Older people ≥60 (817) - 417 attenders - 400 non-attenders All frail with no cognitive impairment. Groups matched by age (within 5 years), gender & GP, ADL and IADL status.	[See Iecovich & Biderman 2012] Interviews	Structured interviews: - Quality of life: WHO Quality of Life Scale (subjective & validated) 4 domains: - physical health (e.g. extent that physical pain prevents from doing what need to do; how much medical treatment needed to function in daily life); - mental health (e.g. how much enjoy life; to what extent life feels meaningful); - social relationships (e.g. satisfaction with personal relationships; 1 item on satisfaction with sex life excluded due to refusal to answer); - environment (e.g. how safe feel in daily life, how healthy is physical environment). Measure included 2 items relating to general health status (how rate QoL; satisfaction with health). Data about ADL, IADL, self-rated health and economic status (actual and perceived) - [See Iecovich & Biderman 2012] .	Attenders experienced <i>significantly</i> higher levels of emotional, physical and overall quality of life (QoL) than non-attenders, but there was no <i>significant</i> difference in environmental quality of life between attenders and non-attenders. A higher level of wellbeing was <i>significantly</i> connected with social benefits, needs being met and DC attendance acting as respite for family carers. Most variables explaining higher QoL were subjective not objective (i.e. self-rated health, perceived economic status instead of actual morbidity or income, number of weekly visits, length of visit). Iecovich & Biderman suggest that interventions to change attitudes and address feelings would be best offered by DCs to promote QoL.	Sample may not be representative of attenders across the country. Generalisation may be restricted to social models of DC. Causality cannot be determined by a cross-sectional study.
Iecovich and Biderman (2013c) Israel Peer-reviewed journal <i>Gerontologist</i>	To examine the extent to which users and non-users differ in frequency of use of out-patient health services (visits to specialists) and in-patient health services (number of hospital admissions, length of hospitalisations, and visits to emergency departments). <i>Day Care Centre (social model)</i>	Medical offset (use of one service reduces use of another)	[See Iecovich & Biderman 2012] ----- Older people ≥60 (800): - 400 attenders of 13 day centres - 400 non-attenders. Groups matched by age, gender, functional status and GP, but socio-economic characteristics were <i>significantly</i> different.	[See Iecovich & Biderman 2012] Interviews. Health service use data provided by health care organisation participants were members of.	Health care service use data drawn from the central computerised data held by the health care organisation that participants belonged to: - total visits to specialists (e.g. cardiologist, neurologist) - number of admissions to hospital and total bed days - number of visits to hospital A&E departments. Structured interviews: - IADLs, ADLs, self-rated health, co-morbidity, DC use and income (actual and perceived) [See Iecovich & Biderman 2012] Statistical analysis undertaken.	No <i>significant</i> difference in use of health care services between attenders and non-attenders was found. Use was related to morbidity rather than attendance at DCs. No offset effect was found between DC attendance and hospital/specialist usage. Day centres did not meet people's actual health needs. Iecovich & Biderman report this finding to be surprising given research positive evidence concerning psychosocial interventions and medical offset. Iecovich & Biderman suggest that there may be a role for health services (including rehabilitation) to be offered within DCs, particularly given that attenders are a more vulnerable group than non-attenders (unmarried, lived alone, lower economic status). Israeli DCs generally conform to the 'social model', only providing health promotion programs to a limited extent.	Use of primary care may be more suitable measure of medical offset for a social model of DC with proven psychosocial benefits. Cross-sectional study – causation cannot be determined.
Ishibashi and Ikegami (2010) Japan	To establish the validity of the policy to encourage the use of day care services and to contain the use of home help services by observing decline in functional status	None.	Selected from a dataset , held by municipal government, of records of 834 people ≥65 who had applied for long-term care insurance (LTCI) for first time Apr 2007-Oct 2008 & were confirmed eligible for level 1,	Quantitative – prospective longitudinal Data collected from municipality maintaining database every 6 months	Service use was tracked and participants' reassessment (eligibility level data) was collected 6 monthly over 19 months. Socio-demographic characteristics (gender, age, and economic status as indicated by level of premiums).	Functional status of new day care users with low needs (level 1: DC being attended as a preventive service) was more likely to decline <i>significantly</i> over 18 months than that of new home help users. Of DC attenders, 37% had declined to level 4 compared with 21% of home help recipients (excluding 0.8% died and 0.8% moved away). Rates of decline were similar regardless of number of days attending DC.	Rate of take up of day care was lower than national average whereas take up of home help was higher

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Peer-reviewed journal <i>BMC Health Services Research</i>	as measured by eligibility level. <i>Day centre model</i> <i>Day Care.</i>		accounting for 88.6% of all those certified level 1. Of 340 who had started using services within 3 months of certification, 102 used day care and 139 home help. Older people (241) (102 attenders & 139 home help users) with lowest level of LTCI eligibility: 1 (1-3 = IADL disability). Groups similar in gender and economic status, but attenders older by nearly 5 years.	for an average of 18 months.	Information regarding the relationship of the primary caregiver and time spent providing care were obtained from the care plans drawn up at the start of service use. Statistical analysis was carried out.	Although this appears to suggest that home help is more effective in maintaining functional status than day centres, Ishibashi & Ikegami proposed that the most likely reason for this was their older age. They were older than home help recipients (over half the sample was aged over 80). People with a co-residing primary carer were more likely to attend a DC whereas people with no primary carer, or where the primary carer did not co-reside, were more likely to choose home help. <i>Only people using either day care or home help were included. People using both were excluded (n=23).</i>	in area study took place.
Kelly (2017) Canada Peer-reviewed journal <i>The Gerontologist</i>	To explore the impact of attenders' extended time living in the community and 100-day rates on A&E attendance, acute care hospitalisation and days in hospital. <i>Adult day services</i>	None.	Selected from a dataset. 812 attenders and 5,445 non-attenders (n=6,257) who were aged ≥65 at the time of newly enrolling in the provider's 'home health' programme over a 2-year period (1 st July 2012 to 30 th June 2014) and were in the programme for ≥90 days. These people were monitored up to 30 September 2014 (follow-up date). Original sample, excluding those exceeding monthly service hourly limit (n=47) or who used respite (n=159) was 7,184 and those who did not have a spousal or adult child primary carer (n=927).	<u>Quasi-experimental</u> Retrospective analysis of administrative data held by one provider of services (including adult day services and in-home services).	Administrative data from provider's hospital (no. A&E attendances, admissions and days of hospital stay) over the 180-day period (6 months) prior to service enrolment were obtained for each of the 6,257. Using administrative data from assessments (socio-demographic, health, behaviour, carer burden and participant/carer views concerning whether participant would be better off in long-term care, statistical analyses were carried out to ascertain propensity scores (based on hospital and assessment data) which were used to match each attender with a similar non-attender. Further statistical analyses carried of matched pairs.	Before matching analysis: Over the 180-day period prior to programme enrolment, future attenders had fewer A&E attendances, hospital admissions and hospital days than future non-attenders. Matched pair analysis: Attenders spent <i>significantly</i> fewer days in hospital than non-attenders and hospital stays were <i>significantly</i> shorter than among non-attenders. Rates, but not numbers, of A&E attendance and hospital admission were also <i>significantly</i> lower among attenders. Attenders' also remained in the community for significantly longer. Attenders averaged 1.7 days a week and 8.6 months at day centres. Kelly <i>et al.</i> speculated that their greater exposure to health care professionals meant that health problems would be noticed before becoming acute. The attender group had fewer women, were less likely to live alone and more likely to have a burdened spousal carer, were slightly younger (average 81.6 compared with 83.8 years), more clinically stable and more able to manage their personal care without help. Dementia was more present in attenders (31.8%) than in non-attenders (17.4% of unmatched non-attenders).	Canadian day centres are designed for reasonably functional older people who are well-supported and living in the community. Having excluded people without a spousal or adult child carers may have limited the generalisability of the findings.
Kelly <i>et al.</i> (2016) Canada Peer-reviewed journal <i>Journal of Applied Gerontology</i>	To investigate centre attendance 'dosage' on time to institutionalisation <i>Adult day services</i>	None.	Selected from a dataset. 1,477 attenders and 14,535 non-attenders (n=16,012) aged ≥65 who had enrolled in the provider's 'home health' programme over a 4-year period (1 st Jan 2009 to 31 st Dec 2012), whose administrative records were complete and whose care was not managed by carers (i.e. not 'very high needs'):	<u>Quasi-experimental</u> Retrospective analysis of administrative data held by one provider of services (including adult day services and in-home services).	Participants were grouped into 4 levels of attendance 'dosage' deemed likely to impact on institutionalisation. Analysis of total days and hours of attendance undertaken to ensure categories reflected both frequency and duration of attendance. Dosage categories were: High (equivalent of at least 96 days over 12 months i.e. average 1.8 days weekly – includes attenders average 3.5 days/week for 9 months and average 1.05 days/week over 16 months; n=513), Moderate (those whose attendance fell in between Low and High, n=434), Low (equivalent of a maximum of 18 days over 12 months/maximum average of 0.35 days weekly, n=530) and None (n=14,535).	Those in the High attendance group remained in the community for longest, followed by those in the Moderate group, then the Low group (i.e. effect increases systematically with consistency of attendance). Risk of institutionalisation decreased <i>significantly</i> with High and Moderate attendance (equivalent to at least of 0.35 days/week over 12 months). Time at home converged for the Low and None groups at one year and at three years for the Moderate and None groups. In the High group, higher numbers of months receiving home health services increased institutionalisation risk; risk was <i>significantly</i> mitigated by attendance. Proportions of people with dementia was low in all groups, but higher among attenders (High 11%, Moderate 13%, Low 18%, None 9%) who also had higher risk of institutionalisation due to carer burden. Non-attenders were older (49% of non-attenders aged ≥85 compared with 36% of attenders; 32% of attenders aged 65-78 compared with 24% of non-attenders) and more likely to be female, married and with less education and to have attended A&E or had a hospital admission in the 90-day period prior to scheme enrolment.	Differing lengths of time remaining in community may have been due to between-group individual differences. Even when group differences, it is impossible to completely isolate service impact although this evidence is strong. It is possible that it was the combined effects of day centres with other in-home services that produced this impact.

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					Two models were created, one included all groups, one only attenders. Using administrative data from assessments (socio-demographic, health, behaviour), family income and participant/carer views concerning whether participant would be better off in long-term care, statistical analyses were carried out to investigate group differences and isolate the impact of attendance. Differences were controlled for.	Attenders were more likely to have spousal primary carer, no carer burden and higher income. Carer burden was slightly lower among attenders' carers than those of non-attenders.	Findings may be more generalisable to a social and emotional model of day centre which is the model this provider operated.
Kuzuya <i>et al.</i> (2006) Japan Peer-reviewed journal <i>Geriatrics & Gerontology International</i>	To examine the effect of day care service on the mortality of community-dwelling older people eligible for the long-term care insurance (LTCI) programme. <i>Day Care & Day Rehabilitation.</i>	None	1,875 OP recruited to Nagoya Longitudinal Study of the Frail Elderly NLS-FE, a study of frail, community-dwelling, dependent people ≥65+ who were eligible for long-term care insurance which determines levels of care provided by applying eligibility criteria, lived in Nagoya city and in receipt of services from the Nagoya City Health Care Service Foundation for OP. ----- 1,673 of OP in receipt of services: attenders (726); non-attenders (947) 89% of original sample (missing data for 202). Groups matched for demographics, health status & medications. 42% of attenders and 30% of non-attenders (35% overall) had dementia.	Longitudinal - prospective cohort study (Nagoya Longitudinal Study of the Frail Elderly - NLS-FE). Comprehensive in-home assessments by trained nurses baseline and 6 and 12 months. At 3 month intervals, data were collected, in interviews, about any events participants experienced including admission to hospital, long-term care admission and mortality	Assessments: - Geriatric Depression Scale short version (GDS-15) (24%, n=391 did not complete due to cognitive impairment) - ADLs – Barthel Index (Data collected from another person where substantial cognitive impairment) - Interviews (service use) - Care management records: diagnosed conditions in Charlson Comorbidity Index, prescribed medications. Statistical analysis of data was conducted comparing differences between DC attenders and non-attenders.	DC attendance was associated with significantly reduced mortality, at 21 months. Day care attendance was found to be protective against mortality for OP with lower ADL impairment, fewer comorbidities, depression but without dementia, and significantly protective for those aged 65-74. DC use was associated with a 32-39% decrease in mortality across attenders regardless of demographic or health characteristics. 13% of attenders (n=94) died compared with 18% (n=174) of non-attenders. When attendance was ≥2 weekly, mortality was significantly lower in attenders than non-attenders, at 44% (2 times a week) and 63% (≥3 times a week). Attending a DC once a week did not reduce mortality. There was lower mortality among attenders who also had a home-visiting nurse. 32% of DC attenders received home help and 40% home-visiting nurse services. Mortality was higher among those with severe cognitive impairment who were unable to complete the GDS (26% vs 13%). Kuzuya <i>et al</i> suggested that being in receipt of more than one service was protective of mortality in frail OP and noted that the reasons behind DCs' beneficial impact are unknown.	Not randomised sample. 42% of attenders had dementia, but findings were presented separately for those with and without cognitive impairment. Mortality in severely cognitively impaired people was not presented separately for attenders and non-attenders. Characteristics of survivors and the dead not given. Findings may not be generalisable to other populations due to differing cultural attitudes and access to DCs.
Kuzuya <i>et al.</i> (2012) Japan Peer-reviewed journal <i>Journal of the American Geriatrics Society</i>	To examine whether use of day care services influenced placement in long term care over 3 years. <i>Day Care & Day Rehabilitation.</i>	None	[As Kuzuya 2006] 1,875 OP recruited to Nagoya Longitudinal Study of the Frail Elderly NLS-FE). ----- OP in receipt of services (1,739) attenders (774), non-attenders (965) Enrolled 1 Dec 2003 - 31 Jan 2004. 93% of original sample (missing data for 136). 1,442 had carers. Groups matched for demographics, health status & medications.	[See Kuzuya 2006] Comprehensive in-home assessments by trained nurses at baseline and 6,12, 24 and 36 months. At 3 month intervals, data were collected, in interviews, about any events participants experienced including admission to hospital, long-term care admission and mortality.	Assessments: - Geriatric Depression Scale short version (GDS-15) (24%, n=412 did not complete due to cognitive impairment) - ADLs – Barthel Index - Zarit Caregiver Burden Interview (20%, n=289 of carers did not complete the ZBI.) (Data collected from another person where substantial cognitive impairment) - Interviews (service use) Care management records: diagnosed conditions in Charlson Comorbidity Index, prescribed medications.	Use of DCs was found to be a <u>significant</u> predictor of a move to residential care over 36 months, as are dementia, age & carer burden: once weekly attendance was <u>not significantly</u> associated with such moves, but attendance for 2 or more days a week <u>was</u> . Significantly more attenders (19%, n=143) had moved into residential care at 36 month follow-up than non-attenders (8%, n=74). Participants (all) <i>without</i> severe cognitive impairment were less likely (11%, n=150) to move into residential care than those with (16%, n=67 movers) 24% (n=412) of the whole sample was severely cognitively impaired. Dementia was more prevalent in attenders (44.2%) than non-attenders (22%), with cognitive impairment being severe in 24% of the whole sample. Hospitalisation rates during 36 month follow-up were similar between attenders (43%) and non-attenders (41%). Attenders used nursing and home-help services more than non-attenders.	Sample not random. Cause and effect between attendance and residential care moves could not be established, nor reasons for these. Users of formal services likely to have higher needs than non-users, and those with greater needs may attend more often. Outcome of such needs may prevail over

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	<i>Day centre model</i>						
					Statistical analysis of long-term care placement and predictors of this over 36 months was conducted.	Kuzuya <i>et al</i> noted that this finding conflicts with their 2006 finding that DC attendance (≥ 2 weekly) reduces mortality at 21 months. <i>Note: Not excluded because one-third of overall sample had dementia [see Kuzuya et al 2006. Included despite high proportion of attenders with cognitive impairment (44%) because findings presented separately for those with and without dementia.</i>	positive effects of attendance. Findings may not be generalisable - differing cultural attitudes and access to centres.
Murphy <i>et al.</i> (2017) Ireland (but study about Wales, UK) Peer-reviewed journal <i>Health and Social Care in the Community</i>	To identify effect of attendance of a purpose-built integrated centre on functional mobility, prescribed medication and wellbeing (psychological and physical) <i>Adult day care centre – integrated care (pilot) (rehabilitative model)</i>	None.	30 new attenders of centre (27 remained after 9 months) 33 non-attenders on a community nursing caseload Inclusion criteria: aged ≥ 18 , willing and able to give informed consent, fit enough to undergo assessment (psychologically and physically), attending centre or seeing nursing team at least once weekly for ≥ 10 months. Mean age: - attenders 77.8 years - control group 82.67 years Groups significantly different in age, mental health, functional mobility.	<u>Quasi-experimental</u> (pre- and post-test) Assessments at baseline, 4 and 9 months. (Nov 2010-Sep 2013)	Functional mobility (Barthel's Index). Psychological and physical wellbeing (SF-12). Some socio-demographic data. Individually-tailored multi-disciplinary therapeutic packages including (e.g.) ADL assistance (toileting, hair, washing), occupational and physiotherapy, other nursing, social work interventions and activities (e.g. music groups, singing, raffles, cooking, craft, gardening). GP visited weekly. Specialist support brought in as necessary (e.g. dieticians, podiatrists audiologists). Transport and lunch were provided.	Attendance was usually weekly (7 hours each day) resulted in a small, but insignificant change in attenders while non-attenders declined. Atenders experienced a small, but insignificant, improvement in physical wellbeing. There was no significant change in functional mobility and no change in psychological wellbeing among attenders. Numbers of medications increased in both groups.	Groups were not closely matched (age, functional mobility and mental wellbeing). Support was individually-designed meaning not possible to isolate impactful factors. Bias may have been present as attenders were volunteers. Small sample meant only large differences could be detected.
Ron (2007) Israel Peer-reviewed journal <i>International Psychogeriatrics</i>	To compare two groups of women receiving care insurance services (at home or at day centres) and to assess which demonstrated higher self-esteem. <i>Day Centres.</i>	Self-esteem affected by several intra- and inter-personal factors including mastery of life and circumstances (e.g. social networks) and self-evaluation (e.g. state of health & ADLs).	Non-random sampling (class and convenience sampling) to ensure equal representation of various characteristic existing the older population (age, years of education, subjective perception of functional abilities). ----- Attenders (150); home care recipients (150) – all women and eligible for care insurance. Apart from living arrangements, no significant demographic differences between levels of social/family support received.	<u>Quantitative</u> Questionnaires administered by interview	Demographic data. Subjective function perception: 10 item scale 'SELF' Satisfaction with service & carers: Falck's scale of 13 statements relates to both service & carers which measures expressive and instrumental satisfaction on a scale of 1-3. Family support: 2 tools examining sources of support over past 2 weeks, grouping these into sources (family, professional, general). Self-esteem: 2 tools - Pearson's 7 item sense of mastery of life and circumstances self-report and a self-evaluation questionnaire (both Likert scales) Statistical analysis.	Regular attendance contributed positively to self-esteem in women who are functionally limited (in sense of mastery & self-evaluation). Self-esteem, sense of mastery over their life and self-evaluation were all significantly higher among recipients of care & support at DCs than at home. Around 70% of variance in self-esteem was explained by: type of service (c.47%), marital status (c.13%) and subjective perception of functional status (10%). Also contributing were satisfaction with service and family/ social support, demographics and self-evaluated health. Atenders significantly more satisfied with 'expressive' aspects of care provided suggesting that DC staff offered better emotional support than home care services. Staff maintained contact with attendees when were unable to attend the centre. Attendees reported feeling less lonely, enjoying company & improved general wellbeing. Ron argued that: 1)- higher self-esteem may be due to structure that attending a DC provides, sense of purpose gained from creativity, sense of belonging, involvement & social ties with other members & staff. , 2)- 47% of difference in satisfaction contributing to overall self-esteem was explained by the services' differing style and character. Care & support at DCs was not on a 1:1 basis, tended to be focused on group activity, & was usually provided by more highly-trained staff. Constraints of time felt less than for home care., 3)- possible explanations for low DC attendance in Israel may include prohibitive cost, personality and security of home.	Correlation with self-esteem does not equate to service impact. Over-representation of minority ethnic group compared with population (52% of sample; around 10% of Israeli population (Africans/Asians).

Author/date, Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
Schmitt <i>et al.</i> (2010) US Peer-reviewed journal <i>The Gerontologist</i>	To assess the association between Adult Day Health Center (ADHC) participation and health-related quality of life. <i>Adult Day Health Centre (ADHC)</i>	None	Convenience sample recruited via social workers / primary care providers. <i>Attendees:</i> 75 of 127 referred enrolled - 34 did not meet criteria, 13 refused, 5 unable to schedule interview). <i>Non-attendees:</i> 79 of 143 referred enrolled - 49 did not meet criteria, 13 refused, 2 unable to schedule interview. ----- Older people - functionally limited, community-dwellers aged ≥55. - 57 newly-enrolled attendees of 16 ADHCs ≥2 days a week completed 12 months (75%) - 67 non-attendees who would have met eligibility criteria for ADHC if referred and had not attended a DC or ADHC in the previous 6 months completed 12 months (85%). Groups matched by age, ethnicity, medical conditions, depression, cognition, immigration history, education, income, marital status. Significantly more non-attendees lived alone.	Quantitative (case-control) 2 months (prospective) - baseline, 6 mths, 12 months (Jan 2001-Apr 2004)	Medical Outcomes Survey Form 36 (SF-36) used to assess at enrolment, 6 and 12 months - multi-dimensional Health Related Quality of Life (HRQoL) instrument covering: - physical functioning (extent to which health-related problems limit moderate or vigorous physical activities) - role physical (extent to which physical health problems affect functioning in daily activities) - social functioning (extent to which physical & emotional health problems interfere with social activities) - role emotional (extent to which emotional problems limit type and amount of regular daily activities) - mental health (lengths of time experiencing various mood states). ADLs - PSMS. Mini-mental Status Examination Geriatric Depression Scale (15) Also collected: - Socio-demographic data - Service use - including hours of home care - Medical conditions	ADHC attendance may enhance OP's QoL. QoL may be a key measure to inform care planning, programme improvement and policy development. Attendees experienced <i>significantly</i> enhanced health-related quality of life in two domains after 12 months whereas these declined in non-attendees. Attendees' daily lives were <i>significantly</i> less restricted by their physical or emotional health than non-attendees (role physical and role emotional). Improvements could not explained by changes to physical or cognitive function or by levels of depression. No <i>significant</i> differences were found, either in-group or between groups, in physical function, social function or mental health after 12 months.	Staffing very different from England: multidisciplinary team including nursing, OT, speech therapy, dietician, counselling, social services.
Shahbazi <i>et al.</i> (2016) Iran Peer-reviewed journal <i>Journal of rehabilitation</i>	To assess the effects of the day centre package on attendees' disability at one centre <i>Adult day care centre – integrated care (bio-psychosocial model)</i>	None	92 older people aged ≥60 - 46 centre attendees of one centre - 46 non-attendees (matched for disability level) recruited by snowballing (who would receive the service after the study) After 6 months attrition of 6 leaving: - 41 attendees - 45 non-attendees Mean age: 68.53 years (range 60-85). No significant differences between groups (age, sex, education, other socio-demographics characteristics).	Quasi-experimental (case-control) Assessments carried out at 4 time points: baseline and 2, 4 and 6 months thereafter. Assessors trained by research team. Different groups assessed cases and controls but checks were undertaken for bias.	World Health Organization Disability Assessment Schedule 2 (WHO DAS II). A 36-item schedule assessing disability in 6 domains: understanding and communication, getting around, self-care, getting along with people, life activities and participation. Service package included rehabilitation services (occupational and speech therapy), educational courses (life skills, healthy lifestyle, self-care programmes), nutrition counselling, providing assistive devices, cognitive enhancement techniques, psycho-social interventions (e.g. art therapy, individual/group therapy) and recreational activities. Attendance: 6.5 hours daily including lunch. Statistical analysis of assessment data.	Findings showed that this bio-psychosocial model of service provision decreased attendee disability and improved functioning compared with a control group whose disability increased over six-months. Within-individual and between-group scores changed significantly. Greatest change was experienced in the domain getting around, followed by getting along with people. Self-care disability decreased, but not significantly, which was expected since 'people who use day services are typically less dependent and can more or less take care of themselves' (p723). Highest mean disability scores at start were in getting around and life activity.	Small sample size. Resources meant a longer study was not possible meaning positive effects after a longer period could not be determined.

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Weintraub and Killian (2007) US Peer-reviewed journal: <i>Journal of Applied Gerontology</i>	To examine the perceptions of participants of adult day services about how intergenerational programming impacted on their <i>emotional</i> wellbeing. <i>Adult day service</i>		Convenience ----- 13 attenders of a day service for frail OP in an intergenerational centre that provided activities for OP, and pre-school child care. Aged 65-90 without diagnosis of cognitive impairment, they were core, regular DC attenders.	Qualitative Interview (face to face)	Participants were asked about their experiences of having co-located children. Socio-demographic data was collected, including contact and proximity to children/grandchildren. The point of data saturation was reportedly reached and thematic analysis undertaken.	All participants had contact with the children. Some had low levels of interaction (n=7); others were actively engaged (n=6) (e.g. reading to them weekly, watching singing/dancing). 'Contact' group enjoyed having children around but did not engage due to poor health or because they had not been invited to/did not feel their help was needed. 'Engaged' group tended to have selected the centre because it was intergenerational (those in 'contact' group had other reasons). 'Engaged' reported feeling more positive about the children and gaining more enjoyment than 'contact'. Levels of engagement changed over study period. One engaged participant reduced it due to progressing dementia and one 'contact' participant increased his contact, perhaps due to participation in the study heightening his awareness. For both groups, having choice about levels of contact was perceived as important for emotional wellbeing and helped attenders to feel respected. That children were well-mannered, enthusiastic and energetic also helped them to feel respected and energised, which they perceived impacted positively on their emotional wellbeing. Also impacting on 'engaged' emotional wellbeing were feelings of being needed by the children, simply enjoying being around them, feeling that they acted as substitute for family particularly since the DC encouraged children to call OP grandma/grandpa. Familial bond was felt by many with distant or no family. 'Engaged' participants also reported feeling calmer. 'Contact' reported their emotional needs as met by peers and DC staff; they did not feel the need to engage with children. Engagement with children was described as 'volunteer efforts' [p382]. Conclusion: intergenerational programmes 1) had a positive impact on OP's emotional wellbeing, 2) offered the opportunity to develop close relationships.	Very small sample limits generalisation, although representative of attenders & levels of involvement with children. Self-reported cognitive status.
Weintraub and Killian (2009) Peer-reviewed journal: <i>Journal of Intergenerational Relationships</i> [See Weintraub & Killian 2007]	To examine the perceptions of participants of adult day services about how intergenerational programming impacted on their <i>physical</i> wellbeing.	By positively impacting cognitive health, intergenerational programming may mediate the relationship between cognitive health and general health	[See Weintraub & Killian 2007]	[See Weintraub & Killian 2007]	[See Weintraub & Killian 2007]	[See Weintraub & Killian 2007] 'Engaged' tended to perceive that intergenerational activities positively impacted on their physical wellbeing more than 'contact' group. Both groups perceived benefit from intergenerational contact which helped maintain their levels of physical activity. Others felt their involvement was limited by their own physical limitations; one engaged participant experienced heightened awareness of her frailty. Another engaged participant viewed physical movement involved as therapeutic and helping him to recover from heart surgery. Although not a physical wellbeing outcome, an engaged participant was reported to feel that he gained a sense of accomplishment from interacting with the children. Conclusion: intergenerational activities, which are often perceived by OP to have a positive impact on physical wellbeing, can be a low-cost supplement to usual activities with peers.	[See Weintraub & Killian 2007]
Wittich <i>et al.</i> (2014) Canada Peer-reviewed journal <i>British Journal of Visual Impairment</i>	To report on the impact of a day centre for people with sight loss on the holistic health of OP with visual impairment. <i>Day centre was located in a rehabilitation centre. Staffing: staff, vols, students)</i>	None	All people newly referred between Sep 2011 - Aug 2012, people took part. ----- Attendees (30) 33 referred – 3 stopped attending within 1 month. 20/30 completed follow-up at 1 year.	Programme evaluation (longitudinal) Baseline, at 6 months, at 12 months. Validated measures	Aimed to establish whether centre was fulfilling aim: to maintain or improve people's biological, psychological or social health while delaying or avoiding institutionalisation. Measures: administered verbally (with audio amplification through a Pocket Talker, if needed) by DC staff or research assistants, all trained in test administration.	15.8% categorised themselves as socially isolated. 10.5% had low social support. Participation in post rehabilitation and group activities (e.g. cognitive stimulation, exercise, arts & crafts, discussion and psychosocial) supervised by an interdisciplinary team (occupational therapist, registered nurse, special-care counsellor, social worker and nurse's aide) may support independent living, and that attendance at the day centre itself partially reflects the accomplishment of the centre to support the physiological and psychological wellbeing of its attenders. Of 30 initial participants, 19 remained living independently in community after one year, 1 moved into residential care, and 10 were lost to poor health, moving away, feeling too young/lack of interest. They concluded that that attendance and	- High attrition at 1 year (33%) - No control group - Staffing very different from England

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					<ul style="list-style-type: none"> - Hearing Handicap Inventory for the Elderly - Visual Function Questionnaire - Geriatric Depression Scale - Friendship Scale and Life Space Questionnaire - Timed Up and Go Test - Activity-Specific Balance Confidence - Montreal Cognitive Assessment Measures. 	participation in the rehabilitative activities partially reflects accomplishment of DC to support attenders' physiological & psychological wellbeing. Carrying out hearing screening improved links with a support programme for people who were deaf or hard of hearing. Screening was introduced as part of a programme evaluation.	
ROLE OF DAY CENTRES FOR INDIVIDUALS / EXPERIENCES							
Del Aguila <i>et al.</i> (2006) Australia Peer-reviewed journal <i>Australasian Journal on Ageing</i>	To investigate service (day care and home care) use and non-use as a function of the interrelationship between characteristics of the individual, network and physical environment of the residence and residential location (neighbourhood).	Functional interdependence framework	<p>Not stated. -----</p> <p>Applicants (40) and non-applicants (40) for day care – all community-dwelling, none of whom already used formal services.</p> <p>Mean age: - applicants 77 - non-applicants 76. Groups matched on age, gender, mental status & physical functioning, but not education or economic status. (Also 52 applicants & 52 non-applicants for home care)</p>	<u>Quantitative</u> Not stated.	<p>Based on a literature review and research with OP, a Functional Interdependence Profile was developed and verified for the study. It included behavioural, cognitive and affective indicators of participants, their residence and locality.</p> <ul style="list-style-type: none"> - Behavioural items: objective question format. - Cognitive & affective items: 'I think' or 'I feel' statements. - Iowa Self-Assessment Inventory subscales - to assess cognitive status & physical health. <p>Statistical analysis carried out to determine differences between applicants and non-applicants.</p>	<p>Service use/non-use results from the interrelationship between functional capacity and capacity of informal networks.</p> <p>OP apply to attend DCs when their informal network is no longer sufficient to meet their needs and their physical home environment is no longer suitable for their (functional) needs. Thus, DCs replace, rather than supplement, informal networks. The transition from being an OP who is managing to accommodate limited functional capacity with support of a narrow informal network to needing replacement services can occur suddenly, brought on by bereavement or changing family living arrangements or other circumstances.</p> <ul style="list-style-type: none"> - <i>Supplementary</i> service: builds on informal support, delivered at home. - <i>Replacement</i> service: replaces informal support; delivered in formal setting. 	No details given about identification or recruitment of participants or how questionnaire was administered. Cognitive status of participants not detailed, but was controlled for in analysis.
Ingvaldsen and Balandin (2011) Norway Peer-reviewed journal <i>Journal of Applied Research in Intellectual Disabilities</i>	To identify senior centre attenders' views of the barriers and solutions regarding the inclusion of older people with learning disabilities in community senior centres. <i>Senior Centre</i>	None.	<p>Purposive – DCs without attenders with a learning disability; 2 local authority & 2 non-profit; covering broad socio-economic groups.</p> <p>-----</p> <p>Attenders (30) of 4 DCs (6-12 from each DC) without a learning disability.</p>	<u>Qualitative</u> Focus groups	<p>Participants were asked about their understanding of people with a learning disability, how they felt about this group attending their DC, what would need to be done for them to access it and what they thought prevented them from doing so.</p> <p>Data analysed thematically using grounded theory approach after which participants checked and verified analysis.</p>	<p>Participants agreed that 'visiting' a DC was important for improvement and maintenance of health. Most (70%) 'visited' weekly as well as volunteering there (e.g. in kitchen). 'Visit' was undefined.</p> <p>DCs were felt to be more than a meeting place. For some, particularly those living alone (70%, n=21), DC felt like a second home. Many agreed that attendance had contributed to being able to remain at home. They perceived that their health was maintained (e.g. reducing loneliness & isolation) by activities provided. Social contact & feeling included were key benefits. It was important to feel included & to belong to a group.</p> <p>However, despite that DCs were for healthy people to support them stay healthy, it was raised that some OP may need to overcome an attitudinal barrier before attending one or the first time as some regarded DCs as synonymous with receiving welfare or going to a welfare centre.</p> <p>Most believed that people with a learning disability (LD) may similarly benefit and may find their lives enriched if they attend and/or volunteer at DCs. A minority were of the view that OP with LD should be welcomed, but supported separately due to their potential need for extra support. They raised financial matters needing consideration, e.g. need for increased staffing & training. Some felt that current attenders would need information about new people with LD to be able to welcome them appropriately.</p>	Small study in 1 area - cannot be generalised, but highlights interesting areas.

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Lund and Englesrud (2008) Norway Peer-reviewed journal <i>Ageing and Society</i>	To examine older people's attitudes towards their own ageing and towards people who are older or frailer than themselves. <i>Senior Centre.</i>	That the cultural & societal contexts of the communal setting are a useful lens for analysing & understanding the perceptions & behaviour of OP.	DC selected in consultation with one of the main organisations that run DCs (Norwegian Health Association). ----- Attendees of 1 senior centre. Participants were drawn from the 2,339 registered community dwelling 'users' & volunteers aged ≥ 60; all lived locally. No. of 'registered users who visit the centre' more than twice a year increased from c.500 in 2003 to 636 in 2004.	Qualitative (ethnographic) Observation	Communal activities and interactions between attendees of centre were observed. Researcher (Lund) volunteered at DC, participating in activities, serving meals etc, and asking questions. Each day, 20-70 seniors 'visited' the DC, some for a specific purpose (e.g. hairdresser, French course, to eat or meet people) while others 'visited' and talked with the same people every day. Field notes were written and categorised into observation, theory and methodology. These were interpreted to identify themes which were then discussed with second author.	Tension observed between attitudes & behaviours towards older & frailer people. OP both wanted to participate in activities they valued, knowing that DC helped them to thrive (i.e. maintain good health and subjective well-being), at the same time as creating distance from frailer attendees who they perceived as a threat – a reminder that they, too, were growing older. Some people conceptualised DC as being something undesirable, for people who were old, isolated and ill, with whom they didn't identify themselves. A few holding this view visited DC after personal recommendation subsequently changing their view to a more positive one. One person continued to visit (she was also 'visiting' another DC) as she considered her visits helped those she didn't identify with. Some regulars distanced themselves from frailty by commenting on aspects of old age (e.g. such as a shuffling walk, a bent back) and some felt a need to explain their presence (e.g. for hairdressing). Volunteering at DC helped people to feel useful which was important for them. Some volunteers recognised their own ageing but were not keen on identifying themselves as belonging to the same 'group' as frailer people and created distance by referring to such people as 'they' or 'them'. 70% of attendees also volunteered at same DC. Staffing: 3.5 permanent posts (manager, a cook, 2 assistants). Volunteers: At least 40 OP, from once-a-month to almost daily, undertaking many tasks e.g. managing the cafe, office work, welcoming new people, organising bridge or computer groups.	Attendance may be of a different style to an English DC, on a more drop-in basis, although some people did 'visit' daily.
Marhankova (2014) Czech Republic Peer-reviewed journal <i>Ageing & Society</i>	(Aim of paper below; aim of study not cited). To evaluate critically the idea of active ageing and highlight the role of gender by focusing on transition to retirement and initial involvement with in day centres.	Successful / active ageing	Large DC in capital with approx.1,000 regular participants. DC in smaller town c.60 regular members, chosen randomly for comparison. ----- Day centres (2 observed). Interviewed: attendees (34); employees (13) Documentation produced by DCs. Mean age:62	Qualitative (ethnographic) Observation Interviews 2006-09	Participant observation: DC1: At least 2 hours observation a day on at least 2 days a week and active participation as a volunteer. DC2: daily operation observed intensively throughout 1 week. Above included informal conversations, recorded in field notes. In-depth interviews were recorded & transcribed. Thematic analysis carried out.	For women, DCs offered the opportunity to focus on themselves in retirement after many years spent focusing on other people's needs. (Retirement also offered men opportunity to focus on what had neglected – but opposite way round). DCs, possibly unintentionally, appeared to focus on women through décor and gendered activities (language classes, arts/craft (pottery, painting, sewing), exercise (relaxation e.g. yoga & belly dancing) – except for chess. Non-regular activities aimed implicitly at women: lectures (e.g. 'how to be healthy and not gain weight'; 'thanks to a healthy diet we shed extra kilos'). Men were, therefore, passively excluded & often seen as 'interlopers'. Women tended to increase their attendance whereas men tended to appear once, except for those enrolled on language/IT courses). Men also behaved differently to women – often disruptively – with efforts to include them often failing. Conclusion: although women are main DC attendees, men should not be seen as not engaging in active ageing activities.	DC model targets healthy, independent OP - resemble social clubs than DCs. Data collected differently in sites. With average age of 62, attendees were baby boomers DCs will wish to attract: lessons may be important. Arbitrary judgement that activities were female-focused.

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	<i>Day centre model</i>						
Salari <i>et al.</i> (2006) US Peer-reviewed journal <i>Journal of Aging Studies</i>	To gain more systematic evidence regarding the operation of territorial claims in three different senior centres. <i>Multipurpose Senior Centres</i>	Altman's concept of territoriality	3 diverse multipurpose senior centres. ----- Attendees (approx. 300 observed; 30 interviewed) across 3 DCs – 10 per centre)	Qualitative Observation in dining areas (120 hours) and interviews (30)	Observation: behaviour. Interviews: activities, social relationships (friendships, disputes, peer and staff interactions) and wellbeing. Interview and field note data were analysed thematically. The point of data saturation was reported to have been reached in interviews.	(Original goal: to examine whether environments and behaviours were age appropriate or infantilising for participants. Territorial behaviours were so striking that these were examined.) Short descriptions of buildings & facilities of each to set scene: 1. Food centre shared with community centre (90 daily attendees). 2. Dance centre (57-77 daily attendees). 3. Diverse centre (42-176 daily attendees). Noted building design challenges with reference to spatial behaviour. Dining rooms tended to serve as 'private' spaces for established groups and 'public' spaces for new attendees (outsiders). Treating what is private space to some as public space may cause conflict. Territorial behaviour (e.g. saving seats in dining areas, strong sense of table identity) observed in two DCs. Although this benefited people already in friendship cliques by reinforcing their social bond, it excluded others, including new attendees. This was observed more in centres without attendee involvement. Salari <i>et al</i> argued that an overall sense of ownership within centre, by means of involvement in its running, may negate the need for small scale displays of resource ownership such as seat saving which is unwelcoming and may discourage people from returning after a first visit. Attendees of one centre said that friendships formed around the various activity groups (e.g. ceramic, exercise classes) and that groups socialised outside the centre. This was centre with least territoriality & culture of seat ownership & table membership. Frames DCs as public 'third places' (i.e. not work or home) and highlights importance of physical, organisational and social environments to how welcoming or excluding a DC is.	Very small samples.
RELATIONSHIPS WITH SOCIAL CARE, HEALTH & COMMUNITY SERVICES / ROLE IN SYSTEM							
Cabin and Fahs (2011) US Peer-reviewed journal <i>Home Health Care Management & Practice</i>	To create a model of primary individual and neighbourhood-level variables for predicting depression among older Americans.	N/A	Brookdale Demonstration Project Initiative database ----- DC attendees (1,870)	Quantitative Secondary analysis of data collected by interview for the Brookdale Demonstration Project Initiative on Healthy Urban Aging (BDI) 2008	24-page survey administered by interviewers in 6 languages. Included the Patient Health Questionnaire, Version 9 (PHQ9) Depression Scale. Statistical analysis of data to identify predictors of depression.	DCs may support the prevention agenda, by identifying hearing and vision impairments (<i>significantly</i> associated with falls), screening for depression, and perhaps offering evidence-based falls prevention programmes and depression treatment in collaboration with primary care or community health centre as well as referring to other services. 7 predictors and 1 comorbidity were found to be statistically <i>significant</i> predictors of depression which was highest with: visual impairment; frequent falls; lower income; little leisure-time physical activity; low satisfaction with neighbourhood; trouble hearing; being disabled; having arthritis/rheumatoid arthritis.	Findings set in context of US public health coverage limitations, however findings applicable more broadly despite systemic differences.
Liu <i>et al.</i> (2015) Singapore Peer-reviewed journal: <i>Journal of the American Medical Directors Association</i>	To trace the evolution of day centres in Singapore and chart directions for the future.	Ageing in place.	N/A	Think piece.	Describes development of the different types of DCs for OP and categorises them. Considers funding, payment and other challenges (e.g. assessment, buildings) and makes suggestions about future directions.	DCs recognised as key to supporting ageing in place, but also as incurring substantial development/maintenance costs. Several models operate, many run by voluntary sector. Buildings are often inaccessible. Communication barriers are common due to many employed professionals being foreign. DCs are a health care service and places can be bought with means-tested health funding. They 'receive funding proportionate to the number of clients they receive and the type of services they provide' which Liu <i>et al</i> class as a 'misaligned incentive' as it results in financially constrained DCs sometimes prioritising potential clients with lower needs. Unnecessary work is carried out as additional assessments in addition to the assessment carried out by the referring health care professional are undertaken. Liu <i>et al</i> recommend that 'to move beyond merely social and custodial roles, the quality of services offered must improve and be rooted in evidence-based practice to be viable non-pharmacological treatments. Even social day care serves a	Discusses DCs for all types of older DC users, including people with dementia, rehabilitation or psychiatric needs, or who are dying who are excluded from this review. Recommendations clearly concerning these groups are not referred to here.

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						therapeutic purpose in providing structure and purposeful activities that could improve the clients' quality of life and maintain their physical and emotional well-being' [p9]. 'Although increasing total capacity is important, it is equally pertinent to enhance capability to cater to the varying and complex needs of the frail elderly. Day care centers must be upgraded to holistically meet the custodial, functional, intellectual, emotional and social needs of clients.' [pe9]....'Day care could be used as a staging point for services such as education, counselling and support to caregivers.' [p10], i.e. are multi-functional buildings. '....engaging in the community is critical in allowing the elderly to age gracefully.' [p10]	
Sanders <i>et al.</i> (2009) US Peer-reviewed journal <i>Journal of Community Practice</i>	To identify barriers to the growth of Adult Day Services in order to inform policy development. Article presents only findings related to views of day centre managers and descriptive data from survey). <i>Adult Day Services (licensed to receive Medicaid reimbursement)</i>		All managers 'administrators' of ADS in state (n=38) were contacted. (Evaluation involved ADS managers, professionals, voluntary providers & carers.) ----- DC managers (25). 28 (74%) completed survey & willing to participate, but 3 unable to due to constraints of time. (66% participation rate)	Evaluation Interviews (telephone) Survey 2007 (Evaluation also used focus groups)	4-page survey: ADS data, including attenders from 2004-7, attender-staff ratio, staff data, funding and reimbursement sources of funding. Semi-structured telephone interview: further information about the ADS, including its history, details of financial functioning, views of state regulations and certification requirements, and current challenges faced. Thematic analysis using grounded theory.	Evaluation commissioned by Iowa's Department of Elder Affairs to better understand why licenced ADS (i.e. able to accept third party reimbursement) were underdeveloped and underused despite growing numbers of eligible older people. At the time, half operated at less than 60% capacity. Survey found that licenced ADS were operating at 70% capacity. Barriers to growth identified by managers concerned: - funding: low Medicaid reimbursement rates that don't cover actual costs & mean subsidy from parent organisation is needed; poor managerial knowledge of budget, spending & funding sources - the system: transport; low political advocacy for ADS (professionals lacked knowledge about their value and overlooked them); overwhelming licensing requirements - the community: poor knowledge of ADS, limited sources of donations; 'service' vs 'business' mentalities – the latter being stronger; limited potential attender and staffing base; stigma associated with ADS – people preferred 'day services' over 'day care' perceiving attenders of the latter to be disabled and older than themselves. Prevalent in rural areas was concern about dependency and others becoming aware of a person's service use. Managers were of the view that misinformation was at the root of such stigma. Conclusion: centralised support would be needed to facilitate validation of their place within the system/care continuum.	Two perspectives missing: Dept of Elder Affairs and licensing body (Dept of Inspection and Appeals).
Vogel <i>et al.</i> (2007) US Peer-reviewed journal <i>Journal of Health and Human Services Administration</i>	Article retroactively applies a formal model for interagency collaboration to describe and analyse the process of collaboration between public health and a housing authority. <i>Senior centre</i>	Stages of Collaboration (<i>formal model for interagency collaboration</i>)	N/A ----- 21 DCs in public housing developments (New York)	Case study of pilot service delivery Programme implemented from 2001-2004.	Interagency collaboration (public health & a housing authority) delivered a health outreach programme in DCs that aimed to support OP living in public housing (i.e. lower income) to age in place by offering health services beyond what housing authority could provide. DC directors selected activities appropriate for their own clientele from the menu of services available. These included exercise classes, healthy cooking demonstrations and tastings, vaccinations (flu & pneumonia), mental wellbeing activities and support groups, health education on a range of chronic and infectious diseases as well as services that were delivered in people's homes (e.g. counselling).	Programme was well-received by DC directors and OP alike. The collaborative programme addressed targets for both partners by supporting them to better address OP's needs and, due to its positive reception, led to spin-off collaborations, and demonstrated how innovation can be created within bureaucratic organisations. Challenges included differing organisational cultures, a lack of resources and managing unplanned expansion. Working became more joined up and integrated over the 4-year period.	Context for programmes' operation very different from England.

Author/date, Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
	<i>Day centre model</i>						
Wick (2012) US Peer-reviewed journal <i>The Consultant pharmacist: the journal of the American Society of Consultant Pharmacists</i>	To discuss the evolving roles of senior centres.	N/A	N/A	Opinion piece	Discusses the potential role that DCs may have for trainee health professionals such as pharmacists by improving their awareness of older people.	Wick observed that pharmacists' knowledge puts them in an excellent position to support the health of DC attenders. She reported that some pharmacists have been involved with DCs for some time by providing health and wellbeing activities in them (e.g. medication reviews, targeted falls prevention) and educating carers (not specified if unpaid family or paid) which may help keep more mobile attenders healthy and active for longer. Wick suggested that there may be mutual benefits of partnering with pharmacists, and other health providers. In addition to older attenders benefiting, there is potential for health professionals and students to improve their awareness of older people by exposure at day centres.	Conclusion based on anecdotal and unreferenced reported experiences but concurs with McGivney <i>et al's</i> findings (2011).
ECONOMIC ASPECTS							
Dabelko <i>et al.</i> (2008) US Peer-reviewed journal <i>Journal of Aging & Social Policy</i>	To examine the development of public reimbursement opportunities for ADS and determine whether these opportunities have addressed client needs. <i>Adult Day Services</i>	Resource dependency theory	N/A	<u>Analysis from policy perspective</u> N/A	Examines ADS development of the from a policy perspective.	Most attenders receive some public funding (medical). Public funding is linked with physical medical needs not psychosocial needs, and with carer respite. Many DCs depend on public funding and have developed techniques to remain solvent: changing what they offer to access funding (buffering) and developing partnerships with to maximise resources (bridging). Buffering has resulted in around two thirds of DCs now providing medical services. Example of bridging given: National Assoc. of Day Services (NADSA, a membership organisation) and American Assoc. of Homes and Services for the Aging (AAHSA, representing not-for-profit home health services, assisted living & nursing homes) have formed a strategic partnership with two potential benefits: 1) for partners - increased clients for DC and home health services as each will refer to the other, 2) for public purse - reimbursement rates for DC cost 95% of home health care. Only 4% of DCs had partnered with AAHSA when article was written. Future DC development could either be led by the availability of resources or by client needs (via funding that is linked with client outcomes). Under a resource dependent model, DCs would become more client-centred to enable evidence to be gathered about outcomes which could be used to access resources.	Funding context and operating model very different from England.

Evidence table - literature not focused on day centres but addressed review question (10)

Author/date Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
Brookes <i>et al.</i> (2015) England Peer-reviewed journal <i>British Journal of Social Work</i>	Article draws on findings from a scoping study which aimed to identify future areas for research to assist councils in developing and commissioning personalised services.	None.	Purposive Part of a wider 18-month study. Local authorities (20) were surveyed. 3 case study areas with high levels of self-directed support take-up were selected. Local authority staff (15, care managers and brokers, commissioners) Service users (23, only 2 were older people) in 3 LA areas.	Qualitative ----- (Survey) Interviews Focus groups 2010-11	(Telephone survey aimed to establish development of personalisation). Progress of personalisation was explored and innovative practice identified. Staff interviews explored changes to ways of working resulting from personalisation; benefits of personalised services; examples of new services/innovations and types of personalised arrangements. Service users (interviews & focus groups): previous use of services and support; experiences of setting up PB and its	5 LA staff were aware of reduced demand in some services, especially DCs which they perceived to be due to a lack of personalised service from DCs or a preference by individuals to use mainstream services instead. 9 staff said that there had been no reduction in demand in their area. 5 staff knew that some services, mainly DCs, had been decommissioned. 2 noted challenges associated with this, including some demand still being present. Most staff noted that there was a lack of suitable daytime activities (<i>but did not refer to specific client groups</i>).	Study aimed to cover DCs for all client groups so is likely not be representative of DCs for OP. LAs with higher percentages of people on self-directed support (personal budgets or direct payments were selected for the study.

Author/date Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
					impact on QoL; good/bad experiences of personalisation and/or PBs; service gaps.		
Chaichanawirote and Higgins (2013) US Peer-reviewed journal <i>Research in Gerontological Nursing</i>	To provide a detailed snapshot of social support networks of health independent living older adults. <i>Senior centre</i>	Complex adaptive systems & social network theory	Convenience – 101 recruited from 14 senior centres & 1 retirement community ----- Healthy OP (95) ≥65 living independently in the community. Mean age:76 94% of whole sample (2 excluded due to low cognitive status using 6 item screener; incomplete data for 4).	Quantitative ----- Interview 2010-11	Face-to-face interviews: - Demographic data - Social network: Arizona Social Support Interview Schedule (ASSIS - Barrera 1981) - relationship patterns, density, size of positive networks (available and utilised), size of negative networks (available and used), support need and satisfaction. Statistical analysis carried out. Levels of independence were calculated based on living arrangements and driving status.	Participants had very diverse social networks. Average number of network members: 6.22 (maximum allowed 7). Range: 1-7. Used networks: Largest available and used networks were for intimate interaction (close relationship in which able to discuss personal matters). Smallest available network was for physical assistance (with ADLs). Used negative networks were small (i.e. those involving potential unpleasant interaction). Need: Participants reported moderate levels of social support need. Highest score was for need for social participation (getting together for recreation). Lowest was for material aid (appreciated objects or money). Satisfaction: Highest satisfaction was for social support; lowest for material aid. Availability & use of psychosocial support was perceived as 'very adequate'.	Generalisability to other populations, particularly the housebound, is limited. Study participants likely to be atypical of DC attenders (72.6% regularly drove; 88% rated their health as good, very good or excellent).
Chen and Berkowitz (2012) US Peer-reviewed journal <i>Bmc Geriatrics</i>	To identify any differences in home and community- based services use between older people grouped into 4 patterns of residential transition, and which services are associated with which pattern. <i>Senior centres.</i>	Anderson's Health Behavioral Model	Purposive People with functional limitations selected as more likely than those without to seek support services. ----- OP (3,085) with functional limitations at baseline (at least 1 disability in ADLs or IADLs or Nagi's functional limitation); all had completed all 3 LSAO II interviews. Mean age: 76.3	Exploratory ----- Secondary analysis of data collected by interview for the Second <u>Longitudinal Study of Ageing</u> (LSOA II) 1994-2000	Data gathered on residential status and receipt of home & community-based services (HCBS) of two types: - <i>non-discretionary</i> services (i.e. require prescription from health care professional) e.g. physiotherapy, skilled nursing - <i>discretionary</i> services (i.e. individual's choice) e.g. senior centres, meals at senior centres, homemaker/companion services, personal care services. Investigated associations between 13 different types of HCBS and 4 types of residential transition patterns at T1, T2 and T3: CCC, CIC, CCI, CII (C= community; I= Institution.	When used in combination, DCs and personal care may enable people to remain in the community or to live in the community following a period in a care home. People who remained in the community throughout used DCs more than other services. DCs were the most commonly used service by people in 3 of the 4 pattern groups. Patterns of service use differed significantly between groups. Chen & Berkowitz noted the lack of research about how use of one service may support the outcomes of another. Largest group was of people remaining the community throughout (CCC n=2,589, 84% of total), which suggests that the finding concerning their use of DCs is robust. CIC was the smallest (n=69, 2%).	Exploratory -unable to establish causal relationships. Adult Day Care not surveyed at T2 - findings refer only to Senior Centres. May be generalisable only to people with light to moderate functional limitations: the most disabled did not participate at T2 & T3. No data on participants' cognitive status. Service use depends partly on service availability (not recorded).
Clough et al. (2007) England Sector press	To identify barriers to service access and what improvements could be made, and to discover the services wanted by older people to support them to remain at home.	N/A	Details not given. ----- Local authority staff in commissioning of services, social workers (32) and nurses (37) (survey). Older people (79) (7 focus groups).	Qualitative Literature review (policy & research literature) ----- Postal surveys. Focus groups.	Relevant to this review: nurses (in frequent contact with less healthy OP) were asked about their priorities for low- level support for OP. Report mainly concerns what OP want, barriers to accessing services & how to reduce these, i.e. not relevant to this review.	Nurses' top priorities were for support to carry out IADLs and ADLs, usually in people's homes. DCs and other services reducing isolation figured among their priorities but it was not specified how they were ranked.	No account of recruitment methods given
Glendinning et al. (2008) Peer-reviewed journal:	To assess progress in developing outcomes- focused services for OP and the factors that help and hinder this.	None.	Purposive. Survey: all adult social care managers & practitioners in an existing network of people interested in developing	Qualitative ----- Postal survey	Survey gathered data about development of outcomes-focused services, involvement of partners, types of activities/ services and for which OP, any	Progress in developing outcomes-focused social care services is relatively recent and somewhat fragmented. Process outcomes were addressed across a range of day care services (and in residential and reablement).	Very few details of process outcomes in DCs.

Author/date Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
Health and Social Care in the Community			outcomes-focused services (n=222) (England & Wales). Case study sites: - 6 LAs with firmly established outcomes- focused service selected from survey respondents. ----- Survey: 54 social care managers & practitioners. (24% response rate). Case study sites: - 6 local authorities with firmly established outcomes-focused services.	Case studies – interviews (82 frontline practitioners & managers) - interviews & focus groups (71 OP using services) 2005	achievements and factors that helped or hinder progress. Service users asked about which outcomes were important to them, their experiences of services & how much these had helped them achieve the outcomes they wanted. With reference to a) assessment, care planning and review processes, and b) service planning, commissioning and development, managers were asked about factors that hindered/helped progress, culture/practice change by frontline staff, whether change had extended to other areas, training/monitoring, and the involvement of OP and carers.	DC attenders reported appreciating the respectfulness they were shown and the personalised, flexible nature of these services. Asian attendees held in high regard DCs that employed staff who spoke their languages. LA staff saw partnership working as facilitating an outcomes approach as it meant additional skills and resources could be accessed. DCs were cited as one of two noted successful examples of services taking multidisciplinary approaches. DCs did not support the maintenance of attendees' social networks/activities outside the day centre. Glendinning <i>et al</i> highlighted challenges associated with differing understandings of 'outcomes' between social care & medical professionals as problematic for integrating service delivery. They noted the potential for different interpretations bring with it a risk of change outcomes dominating the development of services to the detriment of longer term maintenance outcomes. Conclusion: 'day centres could provide excellent quality services, with a high emphasis on process outcomes' [p61].	
Iecovich (2008) Israel Peer-reviewed journal (Journal of Applied Gerontology)	To examine the extent to which various supportive services help to alleviate caregivers' burden. To examine the extent to which caregivers' burden affects various domains of the quality of life of primary caregivers. To investigate the factors that best explain quality of life. <i>Day care centre</i>		Random sample (stratified) of 200 from list of 4,100 recipients of services. ----- 114 primary carers of frail, older family members without cognitive impairment who visited DCs (33) or received live-in (39) or live-out (42) home care. 67% of original sample. 77 not interviewed. 48 refused. 5 identified by social workers as being hospitalised or moved to care home. 24 unable to communicate due to mental frailty, language barriers of deafness. 9 carers refused or were unavailable.	Quantitative ----- Interviews administering validated scales	Face-to-face interviews: respondents asked about socio-demographic characteristics (age, gender education, marital status, relationship to cared-for), satisfaction with various aspects of services provided to them and perceived health status. Validated scales used to assess the latter: - Zarit Caregiver Burden Scale - WHO Quality of Life Brief (26 item version) – subjective measure of QoL related to physical and mental health, social relationships, environment, general health and general QoL. Statistical analysis undertaken to examine extent to which carer & cared-for characteristics, weekly hours of care provided & burden explained the WHO QoL domains.	Carers of people attending DCs experienced better psychological quality of life, measured subjectively, than those whose family member received home care. Carer burden and overall quality of life scores were similar for primary family carers of frail OP attending day centres, and those receiving either live-in or live-out home care.	Cautious generalisation due to study location in 1 large city in Israel.
Ipsos MORI (2014) UK Sector press (policy-related report) Ipsos Mori & Age UK	To gain an understanding of and insight into commonalities and differences in the day-to- day life experiences of older people living with frailty, overarching issues or problems from their point of view and what would help to improve their lives.	None.	Quota 1- Individuals recruited via informal routes through trusted contacts - matching 'pen portraits' of 4 types of frail OP. 2- Visits to DCs to fill gaps in quotas (socio-demographic & pen portrait type). Selected with Age UK (commissioner of study) in 4 areas of England. -----	Qualitative ----- 1-Ethnographic visits (filmed) - 5-6 hours per participant (5) during which an interview took place 2- Focus groups (4) with variety of DC attenders & interviews - (4 telephone; 2 face to face, one which was paired) (May-Aug 2013)	Stage 1: Ethnographic visits including interviews in which OP were asked about daily routine, the impact of frailty, finances, carers and other support- workers, living with long-term conditions and other ailments, healthcare professionals, medication and the future. Informal & formal carers also involved if present. Stage 2: Focus group discussions with a variety of DC attendees based on case studies developed from experiences of stage 1 participants exploring:	4 of the 6 participants attending DCs reported benefits of doing so. - Increased happiness and confidence, which improved overall wellbeing and health and resulted was reported by one participant who felt that attending a DC helped prevent isolation. - Being around other people energised another participant and helped her stay active as she enjoyed helping clear up after meals. - A couple, both attenders of the same DC, enjoyed being able to recount the day's activities to their sons when they phoned. - Another participant highlighted her initial difficulties. She became happy to attend once she got to know people, having initially not enjoyed it when she first started (7 years previously) as she found it difficult to remember people. Researchers reported observing a DC worker taking the time to help a frail attender to work out what she owed for her tea. Since doing so took the worker away from	Very small, but in- depth and therefore insightful although not statistically representative.

Author/date Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
			Frail older people - 6 of 12 interviewees attended a DC. - number & details of participants in 4 focus groups at 3 DCs not given. Whole sample represented diverse cross-section of society.		- commonalities and differences - to what extent are experiences the same or different? - drivers - why do people become frail and what can they do to improve their self-efficacy? - motivations - what motivates or encourages people and what happens when traditional motivators no longer work? Interviews (7), content as above.	other tasks, this was reported to suggest respect for the attender's wish to retain as much control as possible within their life.	
Kane <i>et al.</i> (2006) US Peer-reviewed journal <i>The Gerontologist</i>	To compare long-term care recommendations among various types of health professionals.	None.	Convenience sample (snowball) Part of a larger project aiming to improve computerised long-term care decision-making process. ----- 196 professionals from varying disciplines and work locations (practice & academia): 23 advanced practice nurses, 21 registered nurses, 40 geriatricians, 23 primary care professionals, 12 gerontologists, 46 social workers, 15 people working in health administration and 16 in 'other' areas. 64% of original sample: 304 contacted & willing to participate; 211 returned data, 15 of which were incomplete.	Quantitative ----- Postal A letter with detailed instructions & definitions and a computer disc with scenarios was mailed to participants, completed and returned, then used as a data entry device.	Randomly varied hypothetical scenarios (5 each) presented to participants. Scenarios included systematic variation of individuals' ADL difficulties, extent of cognitive impairment, behavioural problems and incontinence). Participants made recommendations for suitable long-term care treatment options from a pre-defined list including: institutional (assisted living, skilled nursing-facility care, rehabilitation) & community-based (adult placement, personal & medical care, personal care, hospice, day care, informal care). Points were allocated to each type, indicating appropriateness, totalling 100 across each row of individual characteristics. Expert judgement was assumed to be a reasonable method for decision-making given the lack of evidence regarding what type of care works best for people with particular characteristics. Statistical analysis undertaken comparing recommendations for long-term care made by the various different professionals.	Recommendations appeared to be influenced by the professional's background, and hence training and education. However, Kane <i>et al</i> noted that day care may be a special case since advanced practice nurses (health professionals) were most likely to recommend it, and social care professionals (social workers and gerontologists) were not any more positive about it than health professionals. Registered nurses, geriatricians, primary care professionals, gerontologists, social workers and people working in health administration were similarly negative about day care. Advanced practice nurses were not, and tended to recommend day care more often than did other professionals. Geriatricians recommended day care more than GPs did. Using average numbers of points allocated, nursing homes were the most popular (35.3), followed by formal home care and informal care (15.3 each). Less popular were assisted living (11.6), home health care (7.1), day care (6.9), hospice (4.0), rehabilitation (2.8) and adult foster care (1.7). Day care definition: ' <i>community-based program offering structured activities and meals during daytime hours</i> ' [p477]	Cautious generalisation given a convenience sample. It was not possible to vary all potential variables, but this was adjusted for statistically. Multiple self-classification of role was not possible.
McHugh <i>et al.</i> (2015) Ireland Peer-reviewed journal <i>International Journal of Geriatric Psychiatry</i>	To gain an understanding of what mealtimes mean to older people and to healthcare professionals working with them.	None	No details given. ----- DC attenders living independently in community (n=6) Healthcare professionals - dietitians, social policy officers, dentists & occupational therapists (n=10).	Qualitative ----- Interviews (OP) 3 focus groups (healthcare professionals)	Semi-structured interviews with OP explored the meaning of mealtimes. Focus groups discussed the same topic. Transcripts analysed using content analysis.	Themes arising with OP: - Socialising: Some are often alone. DCs offer an opportunity to socialise with peers, even if not everyone gets on with everyone else. - Services: appreciated DCs, meals they ate there and other services received (meals on wheels & home help). - Meal seen as occasions: Table presentation considered important. Some preferred to share mealtimes with others, but those with sensory impairments preferred not to (embarrassment). - Cooking & food prep: Few prepared meals at home, instead eating at DCs, family members' homes or having meals on wheels. - Health & illness: Although most reported sensory impairments or lack of teeth affecting their eating, many were unaware that nutrition & health were linked.	Although a very small sample, this research was in-depth.

Author/date Country Publication	Aims	Theoretical framework / conceptual model	Sampling	Research design & data collection	Study details (data collected, measurements, analysis)	Findings relevant to review	Limitations
						<p>Themes arising with healthcare professionals:</p> <ul style="list-style-type: none"> - Met & unmet needs: Available services appeared to be appreciated. Scarce resources meant that everyone's social & nutritional needs could not be met. - Nutrition: Poor appetites often linked with unaddressed dental problems. Good eating habits important for health. - Autonomy & choice: Autonomy & choices OP make about support must be respected. - Cooking motivation: OP may lack skills, appetite or motivation to cook, particularly if without company, especially after bereavement. - Meals as occasions: Meals seen to be occasions if shared with others. Presentation thought to be important, as was social aspect of eating in company. - Support: Suitable crockery/cutlery supports independence. <p>There is a need to prioritise services offering nutritional & social support which can be delivered concurrently.</p>	
Tucker et al. (2014) England Peer-reviewed journal International Journal of Geriatric Psychiatry	To identify the extent of outreach activity that Community Mental Health Teams for older people provide to mainstream service in the light of the National Dementia Strategy.	N/A	All 457 Community Mental Health Outreach Teams for older people (Nov 2008). 88% response rate (376)	Qualitative ----- Postal survey (free text and pre-coded)	Respondents were asked about the structure, organisation and focus of CMHTs.	<p>Almost half (47.1%) had formal outreach activities in DCs, the second most common venue after care homes (54%). The main activity provided at DCs was education or training by itself (44.96% of teams, n=79) followed by link workers only (19.8% of teams, n=35). Just over a third of teams (15.8%, n=28) provided education/training and link workers. A very small number of teams (4%, n=7) provided education/training and case finding/screening, and a further 4% provided link workers in addition to these two activities. Screening only was provided by 2.8% (n=5) teams and open clinics by 1.7% (n=3).</p> <p>Understaffing affected outreach: a <i>significant</i> minority (18%) reported needing more staff, time with patients or fewer referrals.</p> <p>The survey was carried out just prior to the publication of the National Dementia Strategy.</p>	Types of DCs hosting outreach were not specified. Given that the survey related to the National Dementia Strategy, these may have been specialist dementia services.

Evidence table - literature about interventions carried out in day centres (21)

Author/date Country DC model	Aims	Study design	Sample	Intervention	Outcomes	Limitations
Battaglia <i>et al.</i> (2014) Italy <i>Senior centre</i>	To investigate the effects of an 8 week flexibility training programme on the range of spinal motion in older women.	Quasi-experimental (case-control) 37 meeting eligibility recruited from 45 volunteers at one senior centre.	37 attenders randomly assigned to intervention group (19) or control group (18). All ≥60, cognitively intact, physically able to participate in activity, able to ≥ 80% of training, independent in ADLs and IADLs, no falls in past year. Mean age: 68 (intervention), 69 (control).	Over 8 weeks, two sessions per week of core stability and flexibility exercises: 10 minute warm-up, 50 minutes exercises, 10 minutes cool down. No physical activity intervention for control group. - Spinal ranges of motion (ROM) measured before and after using SpinalMouse r device.	<i>Significantly</i> improved ranges of spinal motion: 16.4% increase in spinal inclination, 29.2% increase in sacral/hip ROM. Insignificant increase in thoracic ROM (22.5%) in intervention group compared with control group from maximum extension to maximum bending position. No significant change in lumbar ROM compared with control group. Conclusion: the training programme was practicable for active and independent older people without ADL needs.	High attrition due to personal reasons in control group (5 of 18) compared with intervention group (2 of 19). Subjective outcomes (e.g. perceived pain) not measured.
Boen <i>et al.</i> (2012) Norway <i>Senior Centres</i>	To reduce depression by addressing social isolation.	RCT Random sample (4,000) from Norwegian Population Register; 111 excluded as care home residents; 2,387 of 3,889 questionnaires returned	55 previous non-attenders (3 DCs) in intervention group 37 control group of previous non-attenders (61 and 77 at start) All with	Weekly 3 hour group programme (7-10 people) for 35-38 weeks over 1 year consisting of transport to DC, exercise (developed by physiotherapists) and self-help group (discussion topics of participants' choice) aiming to address social isolation and increase life satisfaction thereby reducing depression. Control group offered intervention after 1 year but not followed up afterwards.	Small, but clinically <i>insignificant</i> , improvements in levels of depression. Higher improvements in people with milder depression. 40% of women reported new friendships and increased home visits from friends. No differences in friendships among men. '...most of the participants said the intervention meant much to them' (p1).	33% attrition - mainly due to poor health, death or heavy care burden. Study commissioned by DC provider. Aims included producing practical knowledge about how DCs could expand activities, reaching out to OP with loneliness &

Author/date Country DC model	Aims	Study design	Sample	Intervention	Outcomes	Limitations
		61%; included if Hopkins Symptom Checklist-10 (HSCL-10) indicated light depression and not attending a DC).		- Depression: BDI (Beck Depression Inventory). - Social support: Oslo-3 Social Support scale (no. of people so close who can be counted on if great personal problems; level of interest and concern people show in what they do; level of ease to get practical help from neighbours if needed). Life satisfaction based on QoL. Self-reported health. If made new friends or met other participants elsewhere.	Conclusion: this was not the most appropriate model of intervention for depression, but that DCs seem to be suitable arenas for community-based health promotion interventions.	psychological distress & increasing use of DCs.
Dabelko-Schoeny <i>et al.</i> (2010) US <i>Adult Day Health Centre</i>	To explore the feasibility and effectiveness of an intervention designed to promote civic engagement in older people with functional limitations. Aim: to increase well-being (purpose in life, usefulness, self-esteem, and self-perceived health.)	Pilot experimental (case-control) using non-equivalent switching replications. (<i>Site 1 received intervention & Site 2 received services as usual</i>). <i>Site 2 then received intervention & intervention was withdrawn from Site 1</i> .	Attendees (43) of 2 DCs – all with functional limitations, aged ≥60, attending on designated day, with capacity to take informed decision to participate. Mean age: - Site 1 77 - Site 2 76	5 week civic engagement (meaningful activity/volunteering) intervention in 3 phases: - education about community group to be served (e.g. homeless, families of soldiers serving overseas) including sharing of own personal stories - assembling of care packages of donated and bought items - presentation of care packages to representative of community group and recognition of participation (certificates and celebratory event).	Improvements to purpose, self-esteem and self-perceived health were found, but these were <i>not significant</i> . After intervention was withdrawn, participants in Site 1 experienced decreases in self-esteem and self-perceived health that were <i>significant</i> , but scores did not drop below baseline. Intervention was welcome by OP and staff. After the study ended, both DCs formed similar service groups to promote civic engagement. '...there appears to be a continued yearning for generativity, productivity, and connectivity in this population. Adult day programs, and possibly other congregate settings, appear to be well suited to provide opportunities for community involvement and engagement for this population. Civic engagement interventions could be integrated into care plans and become a treatment option for increasing participant well-being' (p700)	20% attrition. 3-item Purpose in Life scale found to be unreliable. Chosen instead of 20-item scale due to cognitive impairments of some.
Dickson <i>et al.</i> (2014) US <i>Senior centre</i>	To pilot test an innovative skill-building intervention to improve heart failure self-care among community-dwelling older adults, specifically the efficacy of a theoretically-derived intervention.	RCT (pilot) 144 of 250 met eligibility criteria and 69 declined leaving 75 who were randomised to intervention or waiting list control group.	Convenience sample of 75 older people with heart failure recruited from cardiology clinics and community settings. Intervention (38) and control (37) group. All had been diagnosed with chronic heart failure at least 3 months previously, aged ≥55, lived in the community, without cognitive impairment that may interfere with study. 56 completed 3 month follow-up (29 intervention & 27 control). No significant differences in self-care scores between groups, but significantly higher HRQoL in intervention group. Mean age: 69.9	Group sessions (4-8 participants) of 60 minutes per week of self-care education run by trained lay health educators over 4 weeks. Sessions focused on 4 major self-care processes: adherence to medication, low-salt diet, monitoring symptoms, management of symptoms. Following assessment of self-care knowledge and practical skill levels, deficits were addressed (e.g. reading food labels, preparation of low salt meals) taking into account cultural and social requirements. Health educators also offered self-care lifestyle coaching and problem solving (e.g. access to care). Control group received usual care and was offered intervention after 3 months. Content based on patient education guidelines) - Kansas City Cardiomyopathy Questionnaire (KCCQ) (23-item health-related quality of life measure that quantifies disease-specific physical limitation, symptom frequency, severity, and change over time, overall quality of life, social interference, and self-efficacy – those dimensions shown to be key aspects of HRQL in persons with HF) - New York Heart Association NYHA classification - Charlson Comorbidity Index (CCI) - Duke Activity Status Index (DASI) (physical function)	Improved self-care in all 3 domains (knowledge of heart failure, management and maintenance) in intervention group compared with control group at 1 month, rising to <i>significant</i> improvement at 3 months which suggested sustainability of effects. No significant change in HRQoL. Dickson <i>et al</i> concluded that 'the health educator model may be an alternative to clinician-based approaches, especially when the focus of the intervention is on promoting self-care' [p194]. Conclusion: 'the health educator model may be an alternative to clinician-based approaches, especially when the focus of the intervention is on promoting self-care' [p194]. Since patients with HF experience high symptom burden and exorbitant healthcare costs, understanding how this intervention might decrease health care costs is needed.	Small sample size. High attrition (25%) due to regional superstorms which interfered with communication, enrolment and data collection, but high treatment fidelity among participants. Cost-effectiveness analysis not built in.

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Fitzpatrick (2010) Canada <i>Senior Centre</i>	To explore whether brain fitness activities have a relationship to mental and physical health among older women.	Self-administered questionnaire	Attendees (257) – female (of 9 DCs) – all were relatively independent & functional and participated in specific cognitive fitness activities at DC they attended. Mean age: 77	Participation in & impact of specific cognitive fitness activities participated in at DC (e.g. strength exercises, aerobic exercises, listening to speakers, volunteering, travelling, computer-based programmes, laughing, paid work, group work, language classes and taking career decisions etc.) measured by self-completed questionnaire covering use of DC, cognitive activities, mental & health status, and demographics. Measurement of mental health included modified version of the Psychological General Well-Being (PGWB) Schedule.	Laughing with others, strength exercises, working together on a project and career decisions <i>significantly</i> related to mental health (spirit, happiness and an interesting life). <i>Significantly</i> positively related to both self-reported physical health and chronic conditions: aerobics, strength exercises, group work, listening to speakers career decisions, computer labs, learning new languages and paid work. 'Brain fitness activities represent a specific type of community activity in which older individuals may find additional intellectual and fitness challenges to promote and maintain physical and mental wellbeing'. [p33]	Cognitive fitness activities not confined to those carried out at DCs – some took place at home, or in other community venues.
Frosch <i>et al.</i> (2010) US <i>Senior centre</i>	To evaluate the effect of an intervention to improve active self-management and activity in older people with chronic conditions.	Quasi-experimental Convenience sample.	116 attendees from 2 senior centres. All ≥55, able to walk and complete questionnaires without assistance. Both groups received financial incentives for completing surveys, and 1 received an additional amount for attending at least 3 screenings. Survey completion rate: 98%. Participants in group with additional incentive were younger, more likely to be BME, with lower education levels and income, reported significantly more minutes walking and higher mental health scores.	Group screenings of 5 videos (20-45 mins each) over 12 weeks aiming to inform about and motivate self-management of chronic conditions prevalent among older people (heart conditions, diabetes, back pain) and advance directives, followed by discussion moderated by a facilitator trained in motivational interviewing (member of research team). Videos were shown multiple times to maximise viewing opportunities. Demographic and health data was collected. Validated measures used at baseline, 12 weeks and 6 months: - Medical Outcomes Study 12-item Short-Form Survey (SF-12) (HRQoL – mental & physical) - Patient Activation Measure (PAM) (activation: self-rated ability to take preventive actions, manage symptoms, find/use appropriate medical care, and make decisions about care with healthcare providers). - WHI brief physical activity questionnaire (enables estimation of number of minutes engaged in walking/moderate/vigorous physical activity in previous week). Likert scales measured subjective perceptions of change (12 weeks and 6 months): willingness to consult GP, confidence in ability to ask GP questions, general health, who has responsibility for managing health and what is done to manage health). Open question about any changes made in how manage condition resulting from programme participation.	At 6 month follow-up, participants attending ≥3 screenings reported <i>significantly</i> increased activation (those with least activation at baseline showed greatest increases) as well as more minutes spent walking, engaging in vigorous physical activity and better HRQoL (mental and physical) compared with those who attended <3 or no screenings. (Differences in moderate activity were non-significant. There were no differences in HRQoL scores at 12 weeks. Significantly higher PAM scores in people attending ≥3 screenings at 12 weeks and 6 months). Among attendees of ≥3 group screenings, there was significantly greater change in willingness and confidence to ask GPs questions, sense of personal responsibility for health, making more changes in activities to manage health and in self-perceived health rating. At 6 months, attendees of the advance directive screening (58% of all participants) were significantly more likely than those who did not attend it to have completed an advance directive (13.4% cf 2.1%) or have the intention to do so (41% cf 17.4%). No participant viewed a video individually despite encouragement and equipment being available, suggesting that facilitation is important. Frosch <i>et al</i> /highlighted that this successful and targeted intervention 'reached people in a setting without the time pressures inherent in primary care' [p1500]..	Participants represented a small sample of attendees and may not have been representative. Physical and mental health scores could have been affected in 2 ways: 1) attendees of more group screenings were more physically active at baseline, 2) scores dropped in those attending fewer screenings while those who attended more remained similar possibly leading to increased scores.
Gallagher (2016) Ireland <i>Day centre providing integrated social and health care</i>	To explore how a discussion form may promote social engagement and learning	Qualitative Exploration of intervention operation and experiences. Thematic data analysis.	<u>Interviewed</u> : 9 6 attendees who regularly participated in cafe, 3 staff (manager, facilitator and the person conceiving the intervention) <u>Participant observation</u> : author participated in intervention and recorded conversations from Feb 2012 to Feb 2013.	Weekly 2-hour facilitated philosophical discussion groups of 10-16 people (Socrates Café). Participants included the centre manager, attendees and visitors (including students). Designed to encourage and enable conversations about important life matters. Facilitator opens with a question and leads discussion and dialogue. Examples: What is goodness? Is happiness a choice? Is money the root of all evil? Replicated Socrates Café model initiated in US in 1992.	Main benefits: social interaction and intellectual stimulation. Attendees got to know each other better; added benefit of this: most were neighbours in adjoining sheltered housing scheme and did not know each other beforehand. As well as improving social engagement, discussions were fun; humour was evident weekly. Participants looked forward to attending. Some found the cafe more appealing than other activities; it was purposeful and meaningful and people with varying levels of disability/dementia joined in, speaking about personal lives, own history and feelings. Mutual understanding and tolerance	Views of participants who attended a few times and decided not to return were not gathered. Claimed improved links with wider community appear to refer mainly to links with residents of sheltered accommodation community where centre was located.

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					improved as did relationships with staff. Having a mixed age group (visitors) and different backgrounds was positive. Attenders' out-of-centre-hours links with wider community improved, e.g. manager made centre bus available for attender-organised evening trip to cinema. Benefits for the organisation: staff got to know and understand attenders better; gave insights into activities/initiatives they may enjoy (e.g. started a choral group); gave opportunity to share information about local events, issues or security matters conveyed by the police; acted as an enabler for participants to provide feedback to staff about day centre. Manager and facilitator saw café as reflecting centre values of 'respect for personhood' (p74). 'The findings suggest that Community Philosophy adds an important dimension of lifelong learning to the more traditional 'leisure/recreational' programmes in elder care settings and this can make a qualitative difference in participants' lives.' (p75) (i.e. counteracts the care and health focus of day centres). '...and benefits for the organisation itself.' (p65)	
Ganz and Jacobs (2014) Israel <i>Senior centre</i>	To examine the impact of a 5 month humour therapy intervention on the physical and mental health of community-dwelling senior centre attenders.	Quasi-experimental. Convenience sample. All members of 4 DCs were invited to participate.	92 attenders of 4 senior centres, all living in the community. Intervention (50), control (42) groups. Attrition 25% (n=23). At baseline, intervention group had higher positive mental health and lower depression than control group. These differences were controlled for in analysis.	12 weeks programme of weekly 2-3-hour workshops (based on a successful pilot programme) run by a professional humourist and a social worker over 5 months. Workshops encouraged the use of humour strategies. Control groups attended DCs as usual and were offered workshops after study concluded. Participants assessed at baseline and 6 months using validated scales: - RAND Health Status Questionnaire-shortened version (health-related quality of life: physical functioning, role limitations due to physical and emotional health, energy/fatigue, emotional well-being, social functioning, pain and general health) - General Well Being Scale (GWB) (psychological wellbeing/mental health: positive wellbeing, self-control, vitality, anxiety, depression and general health) - Brief Symptom Inventory (BSI) (psychological distress). Demographic data. Statistical analysis was undertaken. A mean of 11 workshops were attended by intervention group participants.	Compared with control group participants, anxiety and depression was <i>significantly</i> lower at follow-up in intervention group participants who also experienced improved psychological wellbeing. Improvements were all <i>clinically significant</i> . No effects were observed in general health, health-related quality of life or psychological distress. Easy to implement.	Groups too small to detect moderately significant changes (64 in each group were required). Detailed data not collected about participants' medical comorbidity, general physical health status or medications taken. Study difficult to replicate due to differing interpretations of what constitutes humour therapy.
Henwood <i>et al.</i> (2013) Australia <i>Respite Day Centre (i.e. for people unable to care for</i>	To test the feasibility of a staff-delivered, evidence-based exercise programme for people with functional limitations attending respite day centres.	Mixed methods evaluation / feasibility study: single-group, repeated-measures & staff focus group	Attenders (23) in 1 respite DC. Inclusion: ≥ 65, live in the community, rely on others for ≥ 1 ADL, have no advanced, unstable or terminal illness. Cohort obese with walking speed associated with increased risk of falls and institutionalisation.	Minimum 16 session evidence-based, physically challenging exercise programme that was appended to a low intensity exercise programme. The entire session lasted around an hour. Exercise was initially led by a professional and, after training, by DC staff (registered nurses and qualified activity planners/leaders).	Demonstrated <i>significant</i> benefits with potential to contribute to continued physical independence and reduce risk of falls. Walking speed, lower body strength, hand grip, agility and balance improved <i>significantly</i> . All improvements <i>significant</i> after 16 sessions, except for habitual walk and right hand grip which became <i>significant</i> after 16-24 sessions and 24 sessions respectively. Improvements in <i>dignity</i> were reported (in toileting) by 1, potentially reducing carer burden.	Small group with 30% drop-out Difficult to speculate about delivering prog in a DC that does not normally run exercise classes DC staff were registered nurses & people with accredited qualification in planning, developing, implementing & monitoring activity programmes. Not all DCs will have such staff.

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<i>themselves completely)</i>			Average no. of medications was 5.95 & co-morbidities 5.7.			
Kogan <i>et al.</i> (2013) US <i>Senior centres</i>	To test the effectiveness of a multifaceted exercise and nutritional education intervention for chronically ill, community-dwelling older adults.	Quasi-experimental (pre/post test) Purposive sample.	62 people aged ≥60, with ≥2 chronic conditions, with ≥1 A&E visits or hospital admissions in previous 6 months, and at nutritionally moderate to high risk (screened using Nutritional Screening Initiative non-validated questionnaire). 62 of 318 identified via patient records as meeting criteria participated (19%), having also been screened as suitable by their GP. Mean age 73.5	16 weeks of twice weekly 2 hour classes at DCs, led by dietitians and exercise specialists, at 2 DCs. First hour was low-impact physical activity that progressed from seated to standing exercises. Second hour was education about nutrition for managing chronic conditions (diabetes & high blood pressure) e.g. meal planning, food label reading, portion size. Measured at baseline and 4 month follow-up (face to face): - Depression measured by validated scale: Patient Health Questionnaire - Physical activity self-reported. - Fitness levels measured by performance on 7 tests designed to measure flexibility, strength and stamina in OP (30-second chair stand, arm curls, steps taken on a 6-min walk, 2-min step-in-place, sit-and-reach, back scratch, and 8-ft up-and-go). - Body measurements taken and Body Mass Index (BMI) calculated. At the start, participants met with the dietician to discuss their specific needs and set goals. Participants were given a personalised programme manual. >50% attended ≥26 classes. Mean attendance 21.7 classes. Participants were encouraged to exercise between classes, alone or in company (peer support). Statistical analysis was undertaken.	<u>Significant</u> improvements in physical and mental health were found. <u>Significantly</u> increased weekly exercise by 3.3 hrs (from 2.6 to 5.9) and distance walked during an average day by 1.56 miles (from 0.34 to 1.9 measured by pedometer). The majority (57.7%) did not walk at all at baseline. Almost all (95.1%) reported engaging in some walking at follow-up. <u>Significant</u> reduction in depression (mean scores 5.5 down to 2.8 where <5 indicates minimal/no depression and ≥5 mild-severe depression). At baseline, 45% were mild to severely depressed, reducing to 16% at follow-up (i.e. decreased by 64%), with 84% reporting minor/no depression. <u>Significant</u> improvements in 6 of 7 fitness tests 30-second chair stand, arm curls, 2-min step-in-place, sit-and-reach, back scratch, and 8-ft up-and-go). There was no change in 6-min walk. <u>Significant</u> reductions in 5 body measurements (waist, hips, arm, chest, and leg circumference). Participants lost an average of 7 pounds in weight and lowered both their BMI (by 2kg/m ²) and body fat percentage. Anecdotal evidence suggested that participants provided peer support to one another. Kogan <i>et al</i> speculated that the peer support element and social interaction may have contributed to programme adherence given that high numbers were widowed/divorced/single (71%).	Cause-effect conclusions limited due to lack of comparison group. Small sample size. Long-term activity unknown as short-term intervention. NSI is unvalidated, but a better measure was not identified. Participants were not previously attending a DC.
McGivney <i>et al.</i> (2011) US	To evaluate an 'introductory pharmacy practice experience' whereby university students provide supervised pharmaceutical care to people attending day centres.	Programme evaluation	Attendees (361) in 13 day centres. (215 students)	As part of 1st year university module in pharmacy, comprehensive medication reviews were carried out with attendees of DCs and supervised by faculty members or fourth year students. Students followed up matters raised (e.g.: arranging an appointment with doctor to assess symptoms suspected to be a urinary tract infection, obtaining glucose test strips through Medicare for someone who has been paying for these.) Feedback informing the evaluation of the 2008 and 2009 'experience' programmes was obtained from students, supervisors (faculty staff or 4th year pharmacy students, n=13) and DC staff.	<u>For attendees:</u> 447 medication-related problems identified. Most common: non-compliance (n=176, 39%) and the need for additional medication (n=105, 32%). Others: adverse reactions (n=48), unnecessary medications (n=42), needing a different medication (n=34) and dose too low (n=25) or too high (n=17). Top benefits for attendees reported by DCs: identification of medication problems and better medication use. Additional benefits reported: new health information and the companionship provided during a review. <u>For pharmacy students</u> Supervising faculty members observed that students learnt communication skills, clinical decision-making and professional identification (understanding pharmacists' role as medication managers). 4th year students also benefited from supervising 1st years. They fine-tuned their communication and patient interaction skills, realised that people may be less independent than they seemed, perhaps needing help with medication management, and recognised that properly supervised 1st year students could make an impact on people. Contributed to improving the curriculum by providing an opportunity to put learning into practice which acted as a foundation on which to build skills, by reinforcing to students the reality that patients, and their problems, were real, that	Gaining feedback directly from a selection of attendees might have resulted in additional findings. Only DC staff's perception of benefits were gathered and data on outputs (e.g. number of problems identified.)

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					everything is not always uncomplicated, and by enabling them to see that pharmacists had a valuable role beyond dispensing.	
Mathieu (2008) US <i>Senior centre</i>	To assess whether a therapeutic recreation programme addressing happiness and humour could produce a measurable change in life satisfaction.	Quasi-experimental Pre- and post-test	17 attenders of 1 DC increasing to 25 by end of programme. 15 completed all 10 sessions. (age 65-89) All attendees invited to participate.	Once weekly interactive, experiential 'Happiness and Humor' sessions for 10 weeks. Each included an informational presentation about contributing factors to happiness and life satisfaction (pessimism and optimism; light exercise and music; exercise, nutrition, leisure and attitude and why these were important). Format varied from talks, interactive activities and group discussions, jokes (which were encouraged) and comedy videos. Props were used (e.g. sweets) to generate discussion. Participants were encouraged to share funny anecdotes about their lives. They were given 'laughter prescriptions'. Many shared deep feelings during these group psychotherapy sessions. The Life Satisfaction Scale (LSS) (self-rated validated scale measuring 5 dimensions of perceived life satisfaction: pleasure, determination, goal achievement, mood, and self-concept) was administered pre- and post-test with 15 people who participated in all 10 sessions. Statistical analysis was undertaken.	Self-rated life satisfaction scores <i>significantly</i> improved following programme participation. Group dynamics and sharing were noted to be very effective. The group was cohesive by the fourth session and quieter members began to participate. By the end of the programme, all appeared to feel comfortable speaking about personal matters which, they reported, made them feel better emotionally and psychologically. Participants listened well, served each other refreshments and became very interested in and supportive of each other. Sessions encourages social interaction and participants began to meet socially outside sessions . Anecdotal evidence suggested that they became significantly more optimistic during the programme. Mathieu concluded that this programme can be replicated in DCs and suggested 6 core principles to be used in implementing such programmes.	Very small sample. Some claims unsubstantiated (e.g. participants were observed to feel less lonely).
Morrisroe <i>et al.</i> (2014) US	To improve understanding of urinary incontinence and its predisposing characteristics in older Latinos.	Longitudinal cohort study – 1 year	Attenders (328)	Behavioural intervention (Community-Based Physical Activity Trial) to increase in sedentary older Latinos. Validated scales used: - Physical performance - Short Physical Performance Battery18 (balance, gait, strength, and endurance) - ADLs - Activity of Daily Living (ADL) summary scale (assesses difficulty performing 16 basic tasks). - Health-related quality of Life - Medical Outcomes Study 12-item Short-Form Survey (SF-12) - Geriatric Depression Scale (GDS-5) Steps per day measured using pedometers worn at all times, except bathing or sleeping, for a while week before scheduled data collection. Display was covered in a fabric case to minimise it functioning as a motivational tool rather than a measure of walking level. Statistical analysis was undertaken.	After 1 year, incident urinary incontinence (UI) was lower in those who improved their physical performance (but was still high) suggesting that interventions that improve physical performance may help prevent UI in older Latino adults. Higher mental and physical HRQoL was associated with a lower risk of incident UI. Increase in depression associated with higher incident UI.	No details given of what the intervention entailed. Selection bias, attrition, and possible measurement error. (Missing data may have skewed results. Self-reported data is subject to recall and social desirability bias. Urge and stress incontinence not separated. High attrition at 1 year
Ota <i>et al.</i> (2014) Japan <i>Senior centre</i>	To investigate the effects of physical fitness, posture, and quality of life on community-dwelling older people using pole walking at a day service centre.	Quasi-experimental (case-control) DCs randomly allocated to intervention or control.	66 attenders of 5 DCs in intervention (28) and control (38) groups. All could walk independently or under supervision, attended a DC twice weekly and were not severely cognitively impaired. People unable to use poles because of palsy of the hands/fingers were excluded. No significant differences in baseline data between groups except for height. 57 completed pre- and post-tests (22 intervention & 35 control), 86%. Mean age: 83.	Intervention groups used poles while walking/carrying out ADLs at DC for 3 months while control groups continued moving around as usual. Data was gathered pre- and post-test: - MOS 8-item Short Form Health Survey (SF-8)- validated Health Related QoL measure (general health, physical function, role physical, bodily pain, vitality, role emotional, mental health, and social function). Physical fitness measured using knee extensor strength, back muscle strength, one-legged standing time with eyes open test, and the validated timed up and go (TUG) test which assesses mobility. Posture was measured by videoing participants after placing markers at key points.	Compared with baseline, the intervention group experienced <i>significant</i> improvements in Physical Component of HRQoL (associated with activity & function) and to some aspects of posture (decreased upper cervical angle, i.e. chin up, and pelvic plane angles). There were no changes to physical function, but pole walking appeared to <i>maintain</i> physical function as measured by TUG. There were no improvements to physical function or fitness (e.g. strength of knee extensor, TUG) or changes in upper cervical angle. All <i>significant</i> changes in the control group were negative for OP: slower TUG, and posture - decreased neck slope angle (forward head position), pelvic plane and lumbar spine angle.	Random allocation of DCs mean conditions were different for each group. Small sample size affected power of statistical analysis. Small intervention (9.7 minutes/day and twice/week) although this did mirror actual circumstances.

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				(Pole walking is similar to Nordic walking but without the need for licenced instructor training).	Average total pole walking minutes: 229.3. Average daily pole walking time: 9.7 minutes twice weekly. Ota <i>et al</i> concluded that pole walking could be realistically undertaken at DCs as part of a usual day particularly since it did not involve physiotherapists or occupational therapists who are not usually employed by Japanese DCs.	
Pitkala <i>et al.</i> (2009) Finland	To determine the effects of new psychosocial group rehabilitation on the subjective health, use and costs of health services, and mortality of lonely older people.	RCT	Attendees (235) of 7 DCs self-identifying as lonely.	3 month intervention of weekly 6 hour sessions of psychosocial group intervention work (3 groups: discussion with therapeutic writing, group exercise or art experiences) led by registered nurses, occupational therapists and physiotherapists. Sessions aimed to enhance interaction and friendships between participants as well as to stimulate them socially, and were based on the principles of closed-group dynamics and peer support.	At 2 year follow-up, survival was 97% in the intervention group and 90% in the control group. Intervention group experienced <i>significant</i> improvements in subjective health, resulting in <i>significantly</i> lower health care costs during the 2 year follow-up period (–€ 943 per person per year).	Participants were volunteers who wanted to change their lives - may have exhibited better attendance than OP less open to participating in such activity.
Pitkala <i>et al.</i> (2011)	To determine the effects of socially stimulating group intervention on cognition among older individuals suffering from loneliness.				Wellbeing, cognition and health were found to be inter-related with social networks, stimulating activities and surroundings. <i>Significant</i> improvements in cognition after 3 month intervention. <i>Significant</i> differences in the therapeutic writing group members' cognition compared with their control groups. Differences were not <i>significant</i> in the art and exercise groups. At 12 month follow-up (down to 208), mental function remained <i>significantly</i> improved in intervention group.	
Resnick <i>et al.</i> (2012) US Senior Centres	To explore implementation of telehealth equipment in community-based day centres by collecting information on the logistics and operational considerations associated with implementing nurse-monitored telehealth kiosks and conduct a preliminary examination of blood pressure and other characteristics of hypertensive older people using day centres.	Pilot quasi-experimental (case-control) - 10 months	Attendees of 4 day centres. Case groups (2): 41. Control groups (2): 73	Hypertensive older people who were regular attendees were asked to monitor their blood pressure at least weekly for 10 months after being trained in equipment use. Nurses remotely monitored data (intervention group only), making rapid GP or hospital referrals in cases of clinically relevant changes in blood pressure. Data were retrieved automatically by the telehealth central IT system and monitored daily. Nurses were alerted by email to readings outside GP-defined parameters and then accessed individual data to carry out appropriate follow-up. Blood pressure data for the non-intervention group were not monitored in this way.	Easy access to telehealth monitoring equipment offer the potential for better management of blood pressure and cost savings. Mean blood pressure declined in both monitoring and control groups over the period, but was a higher percentage of people with controlled blood pressure in the monitoring group. Participants readily embraced the technology. By end of the study, 95% were very comfortable with its use. Use of the equipment was highest at 5 months after which it decreased. Nurses would have welcomed mobile notifications of data that needed follow-up. DCs were found to be a suitable location for telehealth equipment to monitor blood pressure. Not only could their location in a familiar community venue mean that monitoring of certain chronic conditions might be built into high-risk people's normal routine, but congregate settings also potentially enable such technology to have a broader reach. Monitoring and intervention bridged the gap between routine check-ups. Senior DC staff reported they would readily house such equipment in their DCs permanently were their purchase and maintenance costs not so high.	Some participants did not comply with instructions, measuring blood pressure too frequently, directly after activities that may have led to increases (e.g. card games) or incorrectly placing the cuff. Use of the equipment decreased after month 5. Small pilot study in rural areas of the US.
Santacreu and Fernandez-Ballesteros (2011) Spain	To build a behavioural treatment for feminine urinary incontinence in order to reduce the involuntary urinary leakage in a group of women volunteers.	Quasi-experimental (pre-post test) – 2 months	Female attendees (14) who had experienced at least 1 incontinent episode in week before starting programme.	Daily pelvic floor muscle training (Kegel exercises) (3 times daily) at home for 2 months (9 weeks), following a class at DC teaching the exercises. In fortnightly supervision sessions, an expert supervisor (no details provided) gave instructions for further exercises. GPs had explained Kegel exercises to all participants, but they had not previously performed them.	Urinary incontinence episodes reduced by 75% after completion of programme. All participants (n=14) completing the programme experienced reduced incontinence episodes, regardless of type or severity of urinary incontinence and health characteristics.	Research design was changed. Initial plan: randomise 37 participants to 2 groups - experimental & control in waiting (to commence treatment 2 months after first group). High attrition (62%, n=23) meant that all became part

Author/date Country DC model	Aims	Study design	Sample	Intervention	Outcomes	Limitations
				Participants were followed up 2 months complete of intervention.	Findings confirmed importance of availability of expert supervision (at least, at the beginning) for the acquisition of a new habit.	of the experimental group & study became very small scale. Attrition due to a) not completing programme (6); b) not having leakages in 1st week of treatment (7); c) caring for family member & no time (3); d) no time (4); e) no reason given (3).
Truncali <i>et al.</i> (2010) US <i>Senior centre</i>	To describe 'Keep On Track, an enhanced and updated version of a senior center-based program that aims to reduce the BP of community-dwelling older adults using peer volunteers, its implementation and evaluation.	Evaluation All DC members were invited to participate.	244 attenders of 6 DCs that had ≥60 daily visitors and 4-6 senior volunteers (recruited from DC membership) and were in low to middle income areas. All had newly enrolled in the BP monitoring programme. Mean age: 73	Over 6 months, blood pressure (BP) measuring sessions were run fortnightly in a volunteer-run programme that aimed to reduce BP by conducting ongoing monitoring in people with or without diagnosed hypertension. New enrollees' measurements were recorded on a tracking card that participants were encouraged to show to their GP. Volunteers also asked if people had taken prescribed BP medications in previous 24 hours. Participants were informed of BP using a low-literacy, colour-coded chart and advised about any actions they should take. An average of 6 volunteers per DC ran the programme. The programme had run for >20 years. Enhancements evaluated included updated hypertension management protocols, enhancing health literacy (via low literacy materials and regular reminders about medication adherence) and links with clinicians (letters informing GPs of study participation were developed). Automated monitors were used to measure BP. Local Health Promotion Unit administered the programme and DCs received quality assurance visits to ensure adherence to guidance and correct measurement technique. Start-up material included volunteer training, 2 automatic BP monitors, tape measures and printed materials. Volunteers were given a manual after receiving 6 x 2 hour sessions of training from health educators in hypertension and practicalities (e.g. measuring BP, record keeping and communicating with participants). DC directors recruited volunteers and sent attendance data to Health Promotion Unit, stored materials and dealt with emergencies (approx. 5 hours p.a.). Some DC funding was dependent on participation in programme. First and last Systolic BP (SBP) measurements were compared using statistical analysis.	43% of participants (n=105) had their BP measured multiple times (mean 4.7 times) over an average of 4 months and the remainder (n=139) only once. 181 (74%) had hypertension at baseline. 92% (n=144) of these were aware of this, 78% (n=121) were taking medication for hypertension and 31% (n=31) were being controlled. Awareness, treatment and control did not differ significantly between single and multiple visitors at baseline. Of multiple-visit participants, 62% experienced clinically relevant reductions in SBP over the intervention period (mean 3.9-mmHg reduction in SBP). Reductions were greatest in those with highest baseline BP (20 participants with baseline SBP >160 mmHg experienced mean reduction of 20.9-mmHg). Maintaining this reduction would lead to healthier ageing. 38% of multiple-visit participants experienced no change or higher BP, possibly due to inadequate documentation, lack of adherence to or limitations of programme design. Truncali <i>et al</i> concluded that volunteer-run BP in DCs was a low cost, low risk, simple model that was effective in reducing BP and had the potential to be sustainable and reproducible. However, more attention would need to be given to communication with GPs.	Pre-post test design does not control for outside influencing factors. Only baseline data was available for 57% of participants. Short evaluation period – some improvements may not have been detected.
West <i>et al.</i> (2011) US <i>Senior centre</i>	To determine whether a translation of the Diabetes Prevention Programme (DPP) Lifestyle programme delivered by lay health educators in senior centres is effective in promoting weight loss in older adults.	RCT DCs were randomised to intervention or control.	228 attenders of 15 DCs (average 15.2 per DC). Intervention group: 116 Control group: 116 All were obese (BMI ≥30), able to undertake moderate exercise (e.g. riding a bike, walking, swimming, without serious cognitive impairment, had not recently lost a substantial amount of weight, were	12 one-hour group sessions of adapted version of the Diabetes Prevention Program Lifestyle behavioural weight-control programme delivered by trained lay health educators; included self-monitoring, stimulus control, problem-solving, goal-setting, relapse prevention. Lay educators used a script; handouts were given to participants. Sessions and individual data collection took place in separate private spaces. Each DC identified 2-3 lay health educators. 40% were community volunteers and 60% DC staff; none had health or	Individuals in intervention group lost <i>significantly</i> more weight than control group: - 38% lost ≥5% of baseline weight compared with 5% of control group (mean loss 3.7kg and 0.3kg - 24% lost ≥7% of baseline weight compared with 3% of control group. Loss of ≥5% is associated with clinical improvements. Adherence was high: 86% attended at least 50% of sessions. Weight loss was positively associated with attendance and diary submission. Participants reported high satisfaction with the	Most participants were female and further research about lay health educator delivered behavioural weight control programmes with men is needed. Weight loss was lower at 4 months under the adapted programme, compared with the original programme, but was made 4 weeks shorter to make it more sustainable.

Author/date Country DC model	Aims	Study design	Sample	Intervention	Outcomes	Limitations
			not under weight loss treatment and did not report recent heart attack/stroke/other condition preventing participation. Mean age: 71.2 93% completed 4-month follow-up.	lifestyle intervention backgrounds. They received 32 hours face-to-face training and weekly support from the research team. Participant goals included 7% weight loss, 25% reduction in calories from fat, graded physical activity (up to 150 minutes/week). Pedometers were provided. Self-completion diaries recording diet and physical activity were reviewed weekly. Data collected: body weight (digital scale) (weekly), percentage loss from baseline to 4-month follow-up and proportion achieving $\geq 5\%$ and $\geq 7\%$ weight loss ($\geq 7\%$ is known to delay development of type 2 diabetes). At 4 months, participants completed a questionnaire about the programme's usefulness and whether they would recommend it. To address concerns regarding lack of treatment for control group participants, these received cognitive training (brain and memory function). Materials were provided to DCs without charge. Data was analysed statistically.	programme: 86% said sessions were extremely useful; 92% would be extremely likely to recommend it to a friend. Session length was just right for 83%; 12 weeks was just right for 73%. Attrition of lay educators was low (95% remained at 4 months; 1 left after moving employers and 1 moved away). Their mean age was 59. Socio-economic characteristics were not associated with clinically significant weight loss (age, gender, education, marital status, employment status). Conclusions: - a lifestyle behaviour modification (Diabetes Prevention Programme) can be successfully delivered by trained lay people as shown by clinically significant weight loss in an intervention group compared with a control group - DCs may be a suitable venue for such a programme.	
Yamada and Demura (2014) Japan Day care	To examine the effect of continuous participation in a day-care fall prevention service on the mobility of community-dwelling older people.	Quantitative Purposive	214 of 334 participants of a fall prevention service. Continuous group: 57 participated continuously for 3 years (mean age: 75.6) Dropout group: 157 participated for only the first year (mean age: 76.6). No significant difference in groups' age and physical characteristics. Remaining 120 were excluded.	Falls prevention service focused on education: twice monthly lectures on improving nutrition, preventing cognitive decline, oral health, improving motor function) (i.e. 24 p.a.). Mobility measurements, taken at 1, 2 and 3 years, were peak and mean transfer velocity of centre of gravity (PV, MV) (during Sit To Stand test) and 10 metre maximum walking speed (MWS). Using statistical analysis, measurements for groups were compared.	No <i>significant</i> differences between groups in any of the 3 measures at 1 year. At Year 3, all three measurements were <i>significantly</i> higher for continuous participants compared with drop-outs. From Year 1 to Year 2, continuous participants, experienced <i>significant</i> increases in peak and mean velocities. Conclusion: continuous participation in a falls prevention service at a DC contributed to improved mobility (as measured by peak and mean transfer velocities and 10m maximum walking speed) in OP living in the community.	Very few details of the falls prevention service are given and the characteristics of the service leader are not provided.

Appendix 12 Illustrative examples of coding used in analysis

CARERS			
Outcomes			
Health and other monitoring; day centre informs re concerns	PEACE OF MIND-FEELING REASSURED		
Knowing attender has a 'role'-purpose-opportunity to contribute			
Knowing attender has someone to talk to about problems			
Knowing attender has social-mental-stimulation-input			
Knowing attender is out-has somewhere to go			
Knowing attender safe, cared for & problems			
Can relax or feels relaxed/less stressed	EMOTIONAL	RESPITE	
Feel less stressed-more relaxed-worry less on attendance days			
Feelings of relief-weight lifted			
Helps keep sanity-prevents carer breakdown			
Free day without attender to think about (responsibilities)	FREE TIME - FREEDOM		
No stream of visitors			
Attender as 'chaperone'			
Free time to do as please/spend with spouse or family/be alone			
Can do housework & holiday packing	PRACTICAL		
Replacement care - took over carer’s responsibilities			
Better relationship	RELATIONSHIP WITH ATTENDER		
Conversation material-quality			
Improved attender’s sociability			
Improves attender’s mood			
Attender more like old self			
Lifeline to carer & wider family	LIFELINE		
Information about carers’ group	INFORMATION		

ATTENDERS	
Motivations for day centre attendance (primary one)	
Something helpful to do after retirement	ACTIVITY-RELATED
To keep mind alive	
Wanting to do activities/something	
Attended with husband who cared for (unclear why)	CARER-RELATED
CHANGE OF ENVIRONMENT-Wanting to GET OUT	CHANGE OF ENVIRONMENT- Wanting to GET OUT
FOR MEALS	FOR MEALS
To address diagnosed mental illness	MENTAL HEALTH (to address illness)
Exercise	PHYSICAL HEALTH
Exercise - referred to drop-in GROUP rehab exercise (health)	
Contact with peers	SOCIAL INTERACTION
Needed-wanted to socialise-see people	
Attenders’ circumstances when starting to think about day centre attendance	
Closure of other DC or club / other DC criteria changed	ACTIVITY-RELATED
Had to stop volunteering	
Retirement	
Something to do	
Somewhere to go	
To keep mind alive	
Carer needed a break	CARER-RELATED
Husband (cared for) referred - accompanied him (unclear why)	
Isolated as a spousal carer	
Not getting out enough	CHANGE OF ENVIRONMENT- GETTING OUT
Stuck at home	
Couldn't get out without help-transport	LOSS OF MOBILITY (independence)-physical health
Decline in physical health - sudden	
General decline in physical health	
Loss of car-stopped driving (independence)	
Anxiety disorder	MENTAL HEALTH-EMOTIONS
Depression - felt low/down	
Felt lonely	
Lacked confidence	
Alone (not bereaved)	SOCIAL INTERACTION-lack of
Bereavement (spouse-partner)-was on own	
Insufficient contact with peers	
Insufficient contact with people - socialising	

Loss of existing social networks (non-group)			
Loss of outside activities - stopped attending other group/club			
Attender naturally sociable/joiner			
Outcomes: added to life (would not get elsewhere)			
A laugh		SOCIAL INTERACTION / COMPANIONSHIP	
Company - friendship generally			
Company - own age			
Feeling part of a group-belonging			
Makes a change			
Proper conversation about real things that matter			
Getting out - nowhere else to go		GETTING OUT OF THE HOUSE	
Place to go without difficulties of trips out			
Likes to be doing something		SOMETHING TO DO	
Opened up new life - something to think about & do			
Trips			
Opportunity to contribute-sense of purpose		MENTAL WELLBEING & HEALTH	
Opened up opportunity to contribute-be useful			
Helped to keep sanity	Feeling better		
Less lonely			
Makes feel happy - helps depression			
More confident & relaxed			
Feeling of control & choice & independence (incl. <i>changes</i> life not adds to it)			
Feeling of freedom			
Nothing added to life			
Outcomes (all)			
Activities keep mind occupied/stimulated		ACTIVITY-OCCUPATION OF TIME	
DC attendance keeps your time occupied			
Different to what would be doing at home			
Doing something vs nothing at home			
Done things wouldn't have done otherwise (e.g. craft, trips out)			
Given something to do/think about -an interest-conversation material			
Specific activities (went there for)			
Access to a garden		GETTING OUT OF THE HOUSE-CHANGE OF ENVIRONMENT	
Gets out of house/4 walls (prison/boring)			
Nowhere else to go-only way to get out-gives chance to go out			
Having a meal		HAVING A MEAL	

Boredom-monotony broken-change-break		MENTAL WELLBEING & HEALTH
Changed-enriched life-opened up new life		
Enjoyment-fun-laughter		
Feel more stimulated mentally		
Feels energised - motivated		
Gained perspective of own situation		
Improved confidence		
Less depressed-sad		
Less lonely		
Lifeline-lifesaver		
More relaxed		
Other - own attitude matters		
Sense of independence & control		
Feeling useful to others-making a contribution-active role to play-opportunity to do so	Sense of purpose	
Purpose/structure within own life		
Do more exercise		PHYSICAL WELLBEING & SAFETY
Health monitoring (& outlet for problems)		
Safe place-feeling safer		
Being more aware of certain things	Made a difference	PRACTICAL SUPPORT, INFORMATION & OTHER SERVICES ACCESSED
More money		
Safer - peace of mind		
Saved money		
Saved trips elsewhere		
Did not say whether made a difference		
Other services used (DC provider)	What accessed	
Personal alarm system		
Services of another provider		
Taxi vouchers-card		
Chiropodist	Within DC	
Clothes		
District nurse now treats at DC		
Hairdresser		
Hearing aid maintenance-batteries		
Help with appointments (staff-vols)		

Information & useful talks		
Massage		
Nails filed & painted (staff-vols)		
Staff-vols helped access something		
Companionship	SOCIAL INTERACTION / COMPANIONSHIP	
Company makes a change		
Contact with own age group		
Contact with people generally		
Contact with people - arguing		
Contact with people - chatting		
Contact with people - hearing people		
Contact with people - seeing people		
Contact with people who are also lonely-similar circumstances		
Contact w range of different people		
Conversation material		
Eating in company		
Friends - made new ones		
Friends - reconnected with old ones		
Laugh & fun & joke		
Proper conversation about things that really matter		

Appendix 13 Illustrative Maps of the Week (2)

Nellie's usual week

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	7 Keeps whole day free for: - blood tests 9 - delivery of medication Cleaner hovers	8 Weekly trip to Tesco. Has permanent booking with Dial-a-Ride for transport.	9 10.30-3 DAY CENTRE Self-pay	10 MONTHLY Coffee mornings at volunteers' homes (organised by day centre provider) (Transport with volunteer driver)	11 MONTHLY Lunch club organised by day centre provider. (Transport with volunteer driver)	At home all day. Does laundry.	
Afternoon	13	14	15	16	17	18	19
Evening	18	19	20	21	22	23	24

Elizabeth's usual week

Elizabeth	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	7	7	7	7	7	7	7
	8	8	8	8	8	8	8
	9	9	9	9	9	9	9
				Daughter visits			
	10	10	10	10	10	10	10
Afternoon	11	11	11	11	11	11	11
				Sister & brother-in law visit (11-12.15)			
	12	12	12	12	12	12	12
	13	13	13	13	13	13	13
Evening	14	14	14	14	14	14	14
	15	15	15	15	15	15	15
	16	16	16	16	16	16	16
	17	17	17	17	17	17	17
	18	18	18	18	18	18	18
	19	19	19	19	19	19	19
	20	20	20	20	20	20	20
	21	21	21	21	21	21	21

MEDICAL

SOCIAL

EDUCATIONAL

FAMILY

PAID CARE

DAY CENTRE

OTHER